# Iowa CASA Advocate Pre-Service Training

# Iowa Child Advocacy Board

## Module 3
## Exploring Concepts in Child Advocacy

Personal Study

CASA
Court Appointed Special Advocates
FOR CHILDREN

## Learning Outcomes

- Explain why a child NEEDS permanency.
- Describe how the understanding of diversity and cultural competence among Advocates benefits the children and families with which they work.
- Recognize the impact trauma, toxic stress and resilience have on children and families, and how it affects the way an Advocate does their work.
- Understand the risk and protective factors that may impact the children and families you will be advocating for.
- Understand Concurrent Planning and how it enhances a child's opportunity for permanence.

## Agenda

1. Introduction
2. Exploring Cultural Competence & Humility
3. Understanding the Impact of Psychological Trauma and Toxic Stress
4. What are ACEs?
5. Resilience
6. Understanding Children
7. Understanding Families
8. Concurrent Planning
9. Wrap Up, Evaluation and Preparation for Modules 4 and 5

# Welcome Back!

Thank you for continuing your training with us!

As you move through this module of training, you will begin to learn about some of the issues facing the children and families you will encounter in your Advocate role, as well as how to approach those issues from a position of cultural competence and humility. You will build on what you learned in Module 1 about the skills required to be an Advocate and in Module 2 about the fundamentals of CASA advocacy.

Our goal in this phase of your training is to help you build a foundation of understanding about the children we serve and their families. Your knowledge and understanding of the concepts covered in this module will be critical in your CASA advocacy. You will be introduced to the concepts of understanding children from a child welfare perspective, cultural competence and humility, how trauma, toxic stress other social stressors impact children and families, what concurrent planning is and what it means for a child's permanency.

In this module, you will be asked to consider what you are learning in the context of your own life and in the lives of children and families. You are also asked to begin considering how these concepts apply to the Myers Case Study. This packet of training material is designed to prepare you for the activities you will practice in the Module 4 and 5, in-person training. Module 6 will culminate in an assignment to outline a court report based on the Myers Case Study.

**It is important** that you complete the reading, video review, and the activities in this module ***before*** attending the Module 4 and 5, in-person training. The skills and methods learned and practiced in this independent study will be needed in the group training. **At the conclusion of this module, please complete the evaluation form and submit it to the trainer of the Module 4 session you registered to attend. Trainer Contact details will be provided prior to the session.**

# Exploring Cultural Competence & Humility

Understanding issues related to diversity, culturally competent child advocacy and cultural humility is critical to your work as an Advocate. It can enhance your ability to see things from new and different perspectives and to respond to each child's unique needs. Developing cultural competence is a lifelong process. This section offers a starting point for understanding these key issues. The Myers Case Study and examples throughout this manual encourage continued exploration.

## Nature of CASA (Court Appointed Special Advocate) Program

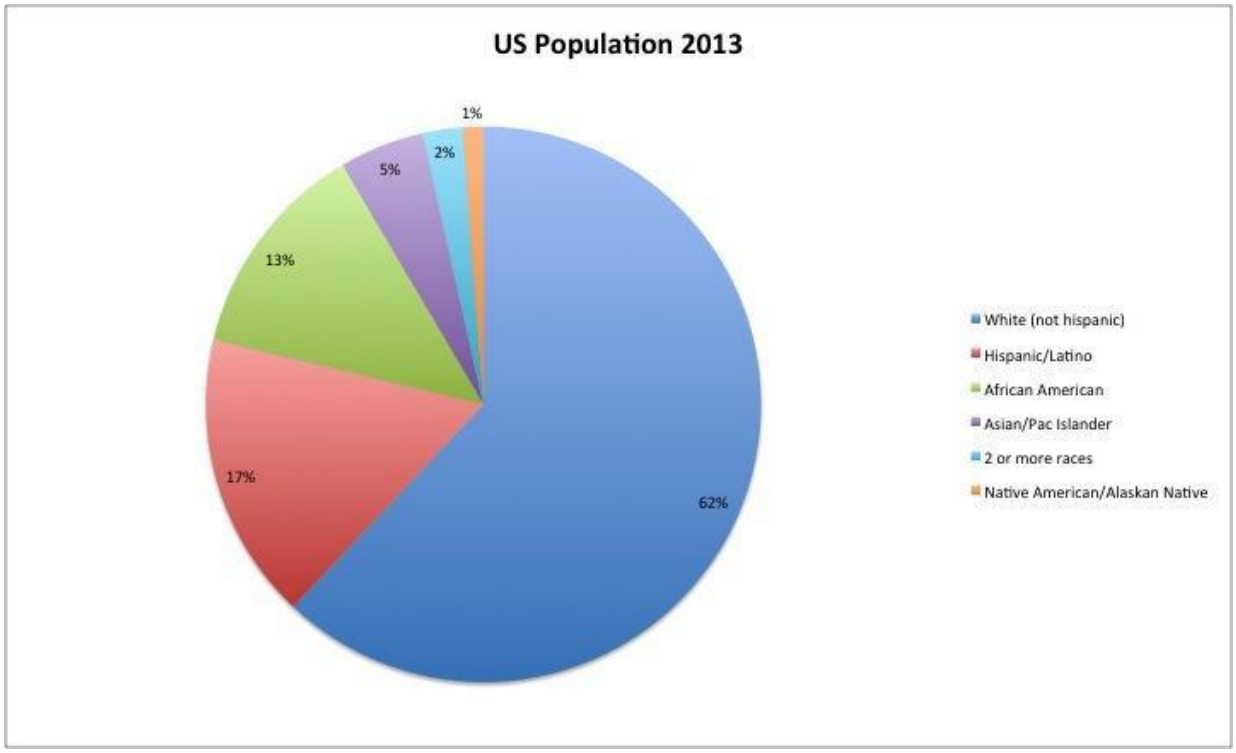
A diverse child advocacy network helps us to better understand and promote the well-being of the children we serve. Embracing diversity and practicing cultural competence and humility, makes us better advocates. It provides fresh ideas and perspectives for problem solving in our multicultural world, enabling us to respond to each child's unique needs.

## The Value of Diversity

As a general term "diversity" refers to difference or variety. In the context of CASA Advocacy work, "diversity" refers to differences or variety in people's identities or experiences. Some examples would be: ethnicity, race, national origin, language, gender, religion, ability, sexual orientation, and socioeconomic class.

## Diversity Wheel

The Diversity Wheel offers a starting point to recognize different levels and types of diversity. The center of the wheel represents internal dimensions that are usually most permanent or visible. The outside of the wheel represents dimensions that are acquired and change over the course of a lifetime. The combinations of all of these dimensions influence our values, beliefs, behaviors, experiences and expectations and make us all unique as individuals.




The United States is becoming increasingly diverse and multicultural.

Approximately 38% of the population currently belongs to a racial or ethnic minority group. The Census Bureau projects that by the year 2100, non-Hispanic whites will make up only 40% of the US population.

As an Advocate, you need to know:

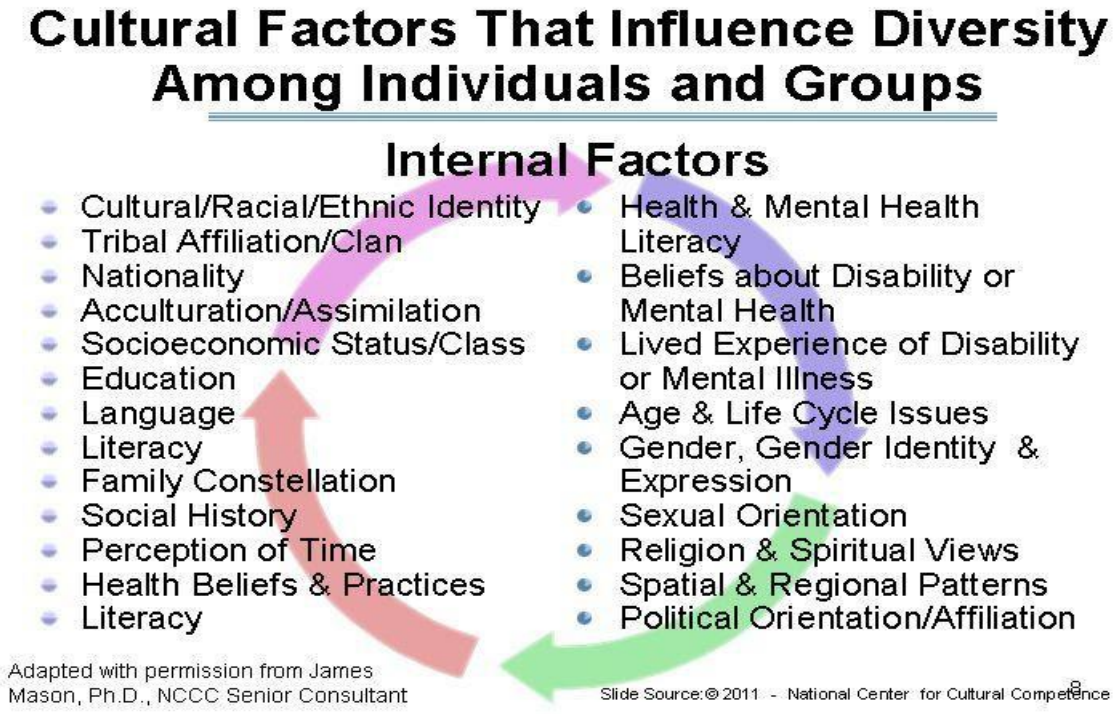
- The identified culture of the family you are working with.
- "Culture" is not limited to race and ethnicity.
- Understanding diversity and practicing culturally competent child advocacy is critical to your work as an Advocate.
- It can enhance your ability to see things from new and different perspectives and to respond to each child's unique needs.
- Developing cultural competence is a lifelong process.

## National CASA's Guiding Principles for Achieving a Diverse Child Advocacy Network

- Ethnic and cultural background influences an individual's attitudes, beliefs, values, and behaviors.
- Each family's characteristics reflect adaptations to its primary culture and the majority culture, the family's unique environment, and the composite of the people and needs within it.
- A child can be best served by a child advocacy volunteer who is culturally competent and who has personal experience and work experience in the child's own culture(s).
- To understand a child, a person should understand cultural differences and the impact they have on family dynamics.
- No cultural group is homogenous; within every group there is great diversity.
- Families have similarities yet are all unique.
- In order to be culturally sensitive to another person or group, it is necessary to evaluate how each person's culture impacts his/her behavior.
- As a person learns about the characteristic traits of another cultural group, he/she should remember to view each person as an individual.
- Most people like to feel that they have compassion for others and that there are new things they can learn.
- Value judgments should not be made about another person's culture.
- It is in the best interest of children to have volunteers who reflect the characteristics (i.e., ethnicity, national origin, race, gender, religion, sexual orientation, physical ability, and socioeconomic status) of the population served.

**The Iowa Child Advocacy Board's CASA Program strives to meet these National CASA standards**

As a foundation for expanding your understanding of other cultures, it is important to be thoroughly acquainted with your own. Cultural competence begins with understanding and appreciating your own identity. You are a "culturally rich" individual with your own blend of culture, ethnicity, race, gender, class, sexual orientation, age, religion or spirituality, geographic location and physical and mental abilities.




### Activity: Knowing Your Culture

In considering categories listed above in the Cultural Factors That Influence Diversity chart, think about your culture and life experiences, and how you would describe yourself, your family of origin or your current family situation to someone you know fairly well.

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After you have some thoughts in mind for each of the categories, think about the following questions:

- Are there categories that you would be uncomfortable sharing in front of the large group during the in-person training session?

- What contributes to your feelings of safety when you are asked to disclose personal information?

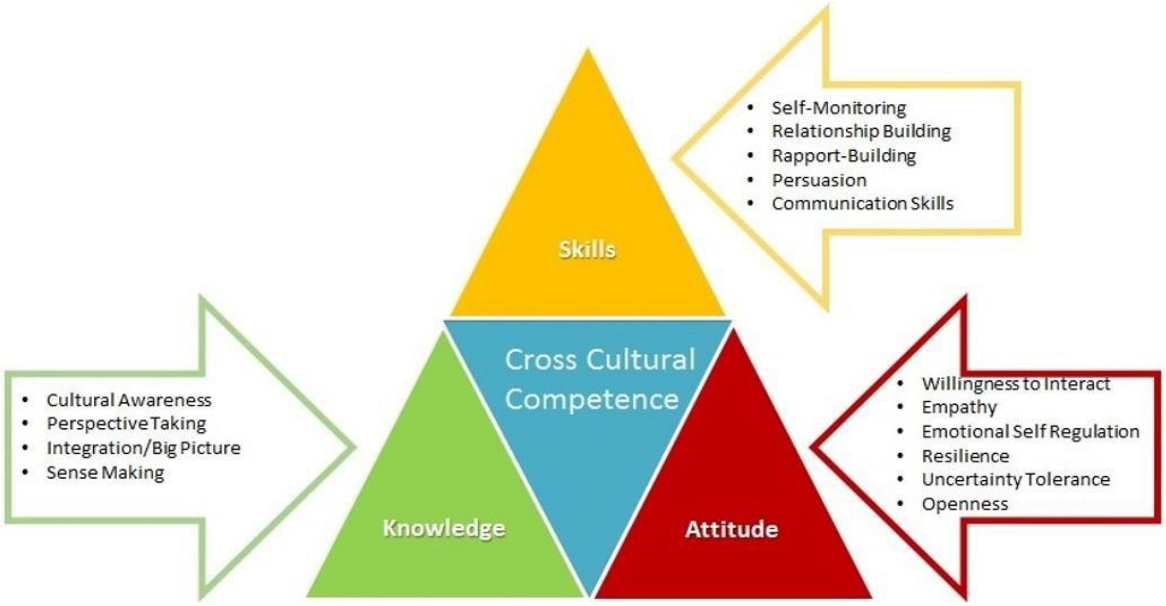
Now imagine that you are a child in foster care, and you are describing yourself to someone who has power over your life – for instance, the caseworker, the judge or an attorney. Consider the following questions:

- How do you think the caseworker or others might perceive you, and what would be the implications?

- When you describe yourself to this person, what might you leave out or enhance to make fit what you think that person would find acceptable? Why?

- If you often had to modify your description of yourself to meet someone else's expectations, what do you think would happen to these parts of yourself?

## Stereotyping vs. Cultural Competence




Picture 1, based on the model of Abbe & Halpin, 2009

Stereotypes based on appearances can impact how a volunteer approaches and builds relationships with families and children. Stereotypes are rigid and inflexible. Stereotypes hold, even when a person is presented with evidence contrary to the stereotype. Stereotypes are harmful because they limit people's potential, perpetuate myths and are gross generalizations about a particular group.

For instance, a person might believe that people who wear large, baggy clothes shoplift. Because some teenagers wear large, baggy jackets, this person may assume that teenagers shoplift. Such stereotypes can adversely affect an Advocate's interactions with children and others in the community. Even stereotypes that include "positive" elements (e.g., "they" are quite industrious) can be harmful because the stereotypes are rigid, limiting and generalized.

## Common Stereotypes

| Positive | Negative | Racial |
|---|---|---|
| All Blacks are great basketball players. | Girls are not good at sports. | All Muslims are terrorists. |
| All Asians are geniuses. | All teenagers are rebels. | All white people have no rhythm. |
| All Indians are deeply spiritual. | All children hate healthy food. | All Blacks are lazy. |
| All Latinos dance well. | All Christians are homophobic. | All Asians are sneaky. |
| All Whites are successful. | Men who like pink are effeminate. | All Hispanics speak poor English. |
| All Canadians are exceptionally polite. | Guys are messy and unclean. | All Jewish people are greedy, selfish money hungry people. |
| French are romantic. | People with tattoos are unprofessional. | All white people are racist. |
| Italians are good lovers. | | |

Unlike stereotyping, cultural competence can be compared to making an educated hypothesis. An educated hypothesis contains what you understand about cultural norms and the social, political and historical experiences of the children and families with whom you work. You might hypothesize, for example, that a Jewish family is not available for a meeting on Yom Kippur, or that they would not want to eat pork.

However, you recognize and allow for individual differences in the expression and experience of a culture; for instance, some Jewish people eat pork and still are closely tied to their Jewish faith or heritage. Another example might be that some African American families celebrate Kwanzaa, while others do not.

As an Advocate, you need to:

- Examine your biases and recognize that they are based on your own life and do not reflect what may be true for others.

And know that:

- Everyone has certain biases.
- Everyone stereotypes from time to time.
- Developing cultural competence is an ongoing process of recognizing and overcoming these biases by thinking flexibly and finding sources of information about those who are different from you.

## Cultural Competence and Disproportionality

***Disproportionality*** is the experience of over-representation or under-representation of various groups in different social, political, or economic institutions. For example, women in the United States are over-represented as single heads of household, and African Americans and Latinos are over-represented in the U.S. prison population.

There is no difference between races in the likelihood that a parent will abuse or neglect a child, but there is a great difference between races in the likelihood that a child will be removed from home and placed in foster care.

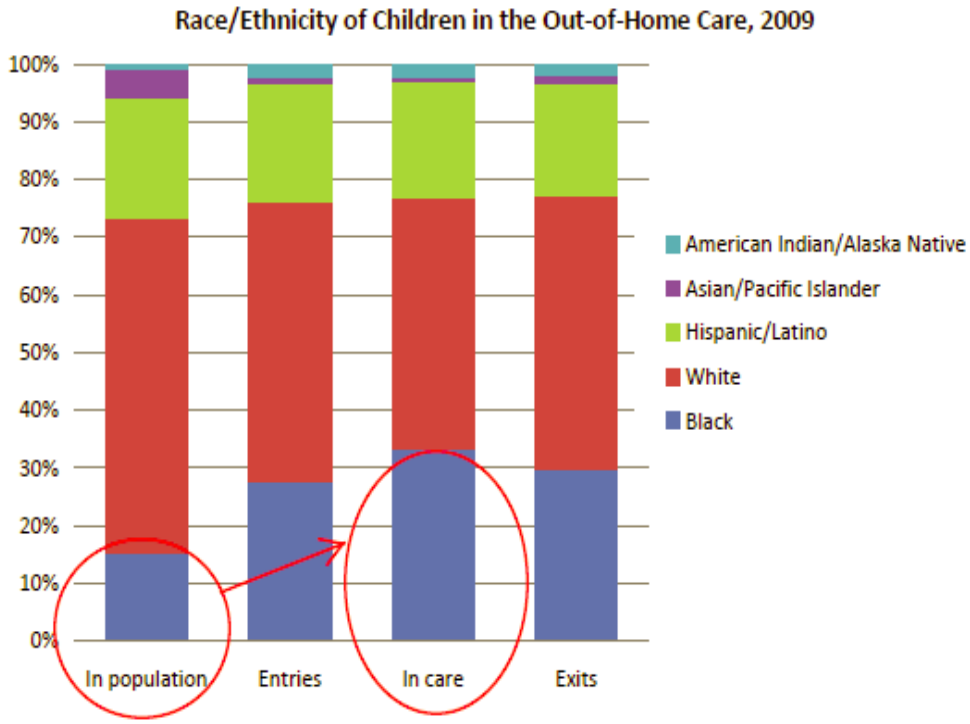
The Government Accountability Office reports that children of color are disproportionately represented in the United States foster care system. In most states, there are higher proportions of African American/Black and Native American children in foster care than in the general child population (Hill, 2006). In some states, Hispanic/Latino children are disproportionately represented as well.

Starting in 1997, the **Adoption and Safe Families Act** (P.L. 105-89) required child welfare agencies to submit data regarding children in foster care to the Adoption and Foster Care Analysis and Reporting System (AFCARS).

In 2000, African American/Black children represented 36% of the foster care population, even though they comprised only 15% of the general child population. Native American children represented 2.6% of the foster care population, yet only encompassed 1.2% of the general child population. Hispanic/Latino children, although not overrepresented nationally, were disproportionately represented in 17 states.

Some states have substantially reduced their disproportionality, however, in 2007, **Iowa's** disproportionality index for children in foster care remained third highest in the United States, and Iowa's disproportionality index for African Americans in the prison system was in the top five in the nation.

Data from 2009 is reflected in the graph, below:




These numbers have led child welfare system stakeholders to make efforts to increase awareness of the issue of disproportionality (Child Welfare League of America, 2003).

In addition to being disproportionally represented in the foster care system, children of color are also *less likely to be reunified* with their birth families.

## Cultural Humility

Considering all of the cultural options with which we might identify, our awareness of stereotyping and the reality of disproportionality, how do we begin and move forward toward cultural competence? By practicing "*cultural humility*".

To practice cultural humility, as an Advocate, not only must you be aware of and be sensitive to the culture(s) of others, you must consider the personal assumptions and beliefs that determine how ***you*** perceive and understand people and their circumstances. You must consider and understand your worldview - the "how and why" in ***your*** perception of others.

Considering cultural issues in your advocacy should begin with recognition that "cultural difference" is simply a relationship between two perspectives. Self-awareness and awareness/acceptance of the other person and any differences in a contrasting culture can and should be used in any encounter, not just with people who are perceived to be culturally "other."

As an Advocate, you will practice cultural competence and humility by:

- Developing and practicing an ongoing process of self-awareness and reflection of your own belief system and worldview.
- Developing a respectful attitude toward diverse belief systems and points of view.
- Exploring similarities and differences between your own and each child/parent's priorities, goals, and abilities.
- Ensuring that children of color have their cultural and ethnic needs met in his/her placement.
- Affecting disproportionate outcomes for an individual child by advocating for timely, meaningful, culturally sensitive services and reunification whenever appropriate.

Developing a working vocabulary related to issues of diversity can help you communicate more effectively with other people and examine what more you have to learn. Please review the Cultural Competence Glossary list on the next three pages.

# Cultural Competence Glossary

***Ableism:*** Discrimination or prejudice based on a limitation, difference or impairment in physical, mental or sensory capacity or ability

***Ageism:*** Discrimination or prejudice based on age, particularly aimed at the elderly

***Bias:*** A personal judgment, especially one that is unreasoned or unfair

***Biracial:*** Of two races; usually describing a person having parents of different races

***Classism:*** Discrimination or prejudice based on socioeconomic status

***Cultural Dominance:*** The pervasiveness of one set of traditions, norms, customs, literature, art and institutions, to the exclusion of all others

***Cultural Competence:*** The ability to work effectively with people from a variety of cultures, ethnicities, races, religions, classes, sexual orientations and genders

***Cultural Group:*** A group of people who consciously or unconsciously share identifiable values, norms, symbols and some ways of living that are repeated and transmitted from one generation to another

***Cultural Humility:*** A lifelong commitment to self-evaluation and self-critique, and a desire to fix power imbalances where none ought to exist, and aspiring to develop partnerships with people and groups who advocate for others

***Cultural Sensitivity:*** An awareness of the nuances of one's own and other cultures

***Culturally Appropriate:*** Demonstrating both sensitivity to cultural differences and similarities and effectiveness in communicating a message within and across cultures

***Culture:*** The shared values, traditions, norms, customs, arts, history, folklore and institutions of a group of people who are unified by race, ethnicity, language, nationality, sexual orientation and/or religion

***Disability:*** A limitation, difference or impairment in a person's physical, mental or sensory capacity or ability. Many communities prefer the term "differently-abled" over "disabled."

***Discrimination:*** An act of prejudice or a manner of treating individuals differently due to their appearance, status or membership in a particular group

***Disproportionality:*** Overrepresentation or underrepresentation of various groups in different social, political or economic institutions

***Dominant Group/Culture:*** The "mainstream" culture in a society, consisting of the people who hold the power and influence

***Ethnicity:*** The classification of a group of people who share common characteristics, such as language, race, tribe or national origin

***Ethnocentrism:*** The attitude that one's own cultural group is superior

***Gender:*** A social or cultural category generally assigned based on a person's biological sex

***Gender Identity:*** A person's sense of being masculine, feminine or some combination thereof

***Heterosexism:*** An ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity or relationship

***Homophobia:*** Fear of, aversion to, or discrimination against homosexuality, homosexuals or same-sex relationships

***Institutional Racism:*** Biased policies and practices within an organization or system that disadvantage people of a certain race or ethnicity

***Language:*** The form or pattern of communication—spoken, written or signed—used by residents or descendants of a particular nation or geographic area or by any body of people. Language can be formal or informal and includes dialect, idiomatic speech and slang.

***Minority:*** The smaller in number of at least two groups; can imply a lesser status or influence and can be seen as an antonym for the words "majority" and "dominant"

***Multicultural:*** Designed for or pertaining to two or more distinct cultures

***Multiracial:*** Describing a person, community, organization, etc., composed of many races

***National Origin:*** The country or region where a person was born

***Person of Color:*** Usually used to define a person who is not a descendant of people from European countries. Individuals can choose whether or not to self-identify as a person of color

***Prejudice:*** Over-generalized, oversimplified or exaggerated beliefs associated with a category or group of people, which are not changed even in the face of contrary evidence

***Race:*** A socially defined population characterized by distinguishable physical characteristics, usually skin color

***Racism:*** The belief that some racial groups are inherently superior or inferior to others; discrimination, prejudice or a system of advantage and/or oppression based

***Sexism:*** Discrimination or prejudice based on gender or gender identity

***Sexual Orientation:*** Describes the gender(s) of people to whom a person feels romantically and/or sexually attracted:

*Heterosexual:* Attracted to the other gender
*Homosexual:* Attracted to the same gender (i.e., gay or lesbian)
*Bisexual:* Attracted to either gender

***Socioeconomic Status:*** Individuals' economic class (e.g., poor, working-class, middle-class, wealthy) or position in society based on their financial situation or background

***Stereotype:*** A highly simplified conception or belief about a person, place or thing, based on limited information

***Transgender:*** Describes a person whose gender identity differs from his/her assigned gender and/or biological sex

***Transsexual:*** A person whose gender identity differs from his/her assigned gender and/or biological sex. Many transsexuals alter their biological sex through hormones and/or surgery.

***Values:*** What a person believes to be important and accepts as an integral part of who he/she is

***Xenophobia:*** A fear of all that is foreign, or a fear of people believed to be "foreigners"

****National CASA Standards require annual continuing education for CASA Advocates in the area of Cultural Competence/Humility.**

## 10 Benefits of Practicing Cultural Competence and Cultural Humility in Your Role as a Child Advocate

**1.** Ensures that case issues are viewed from the cultural perspective of the child and/or family:

- Takes into account cultural norms, practices, traditions, interfamilial relationships, roles, kinship ties, and other culturally appropriate values
- Advocates for demonstrated sensitivity to this cultural perspective on the part of caseworkers, service providers, caregivers, or others involved with the child and family

**2.** Ensures that the child's long-term needs are viewed from a culturally appropriate perspective:

- Takes into account the child's need to develop and maintain a positive self-image and cultural heritage
- Takes into account the child's need to positively identify and interact with others from his/her cultural background

**3.** Prevents cultural practices from being mistaken for child maltreatment or family dysfunction

**4.** Assists with identifying when parents are truly not complying with a court order and when the problem is culturally inappropriate or non-inclusive service delivery

**5.** Contributes to more accurate assessment of the child's welfare, family system, available support systems, placement needs, services needed, and delivery

**6.** Decreases cross-cultural communication clashes and opportunities for misunderstandings

**7.** Allows the family to utilize culturally appropriate solutions in problem solving

**8.** Encourages participation of family members in seeking assistance or support

**9.** Recognizes, appreciates, and incorporates cultural differences in ways that promote cooperation

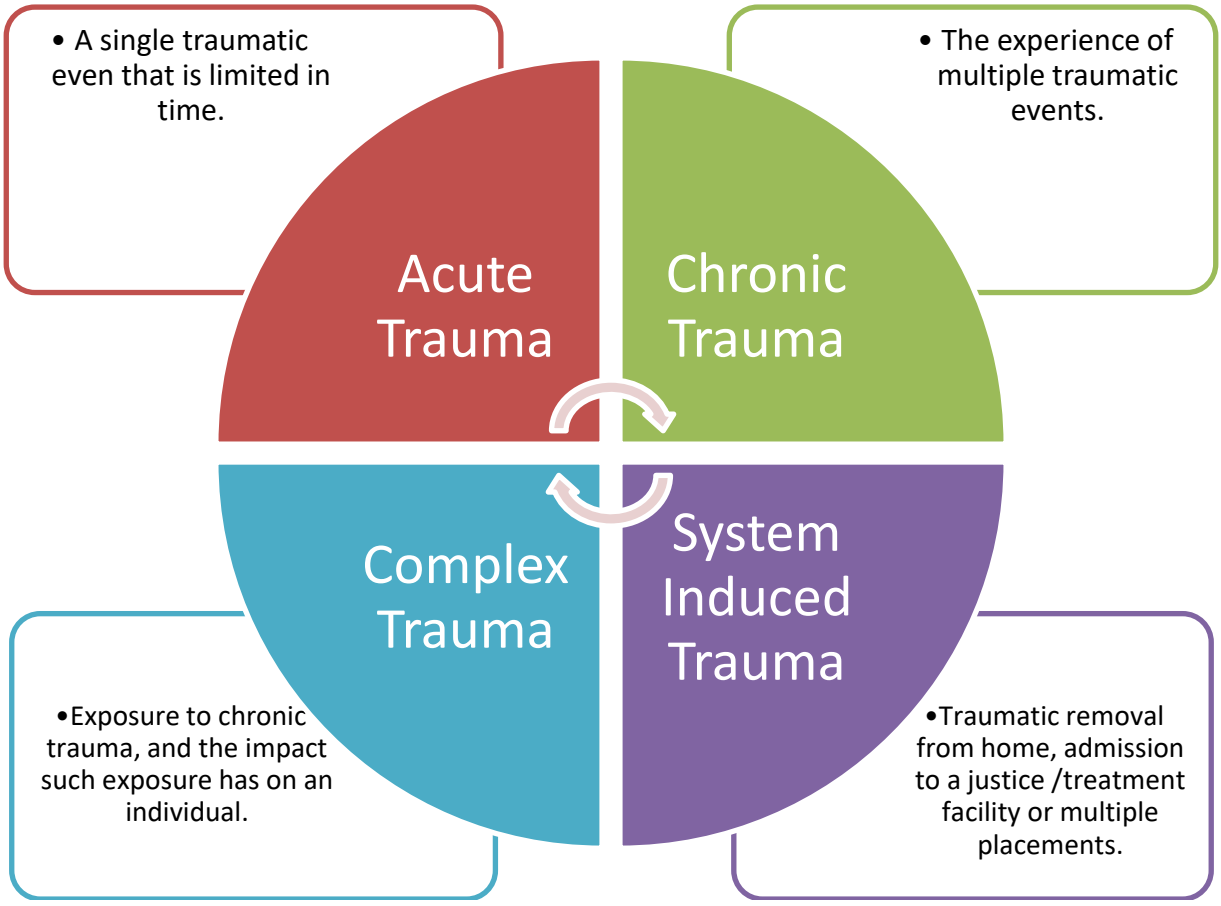
**10.** Allows all participants to be heard objectively

# Understanding Psychological Trauma and Toxic Stress

Psychological trauma is the unique individual experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed, or the individual experiences a threat to life, bodily integrity, or sanity. The threat can be real or *perceived*.

A traumatic event or situation creates psychological trauma when it ***overwhelms the individual's ability to cope.***

## Types of Trauma



## Examples of Traumatic Experiences

- Sexual Abuse or Assault
- Physical Abuse or Assault
- Emotional/Psychological abuse or maltreatment
- Neglect
- Serious accident /Illness or Medical Procedure
- Witness of Domestic Violence
- Victim of or witness to community violence
- Forced displacement
- Natural or manmade disasters
- War/Terrorism/Political violence
- Victim or witness to extreme personal/interpersonal violence
- Trauma/Grief separation
- System induced trauma
- Complex trauma

Early exposure to trauma impairs multiple domains in a child's being, such as attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept.

**(National Child Traumatic Stess Network, 2008), Beverly Tobiason, Psy.D., Chris Swenson-Smith, MSW, Krissa Ericson, MSW**


## Toxic (or Traumatic) Stress

Stress can be defined as a state of mental or emotional strain or tension resulting from adverse or very demanding circumstances. It's important to distinguish among three kinds of responses to stress: positive, tolerable, and toxic.

As described below, these three terms refer to the stress response systems' effects on the body, not to the stressful event or experience itself:

**Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunization.

**Tolerable stress response** activates the body's alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by positive, safe relationships, the brain and other organs recover from what might otherwise be damaging effects.

**Toxic stress response** can occur when we experience strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver or partner substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate support.

When toxic stress response occurs continually, or is triggered by multiple sources, it can have a cumulative toll on an individual's physical and mental health—for a lifetime. The more Adverse Childhood Experiences (*ACEs*), the greater the likelihood of developmental delays and later health problems in adulthood. Research also indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response.

Center on the Developing Child, Harvard University

**"Children's exposure to ACEs is the greatest public health threat of our time."**

Dr. Richard Block, former president, American Academy of Pediatrics

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# So . . . What are Adverse Childhood Experiences (ACEs)?

ACEs are serious childhood traumas that result in toxic stress that can harm a child's brain. This toxic stress may prevent a child from learning, from playing in a healthy way with other children, and can result in long-term health problems in adulthood.

**Adverse Childhood Experiences can include:**

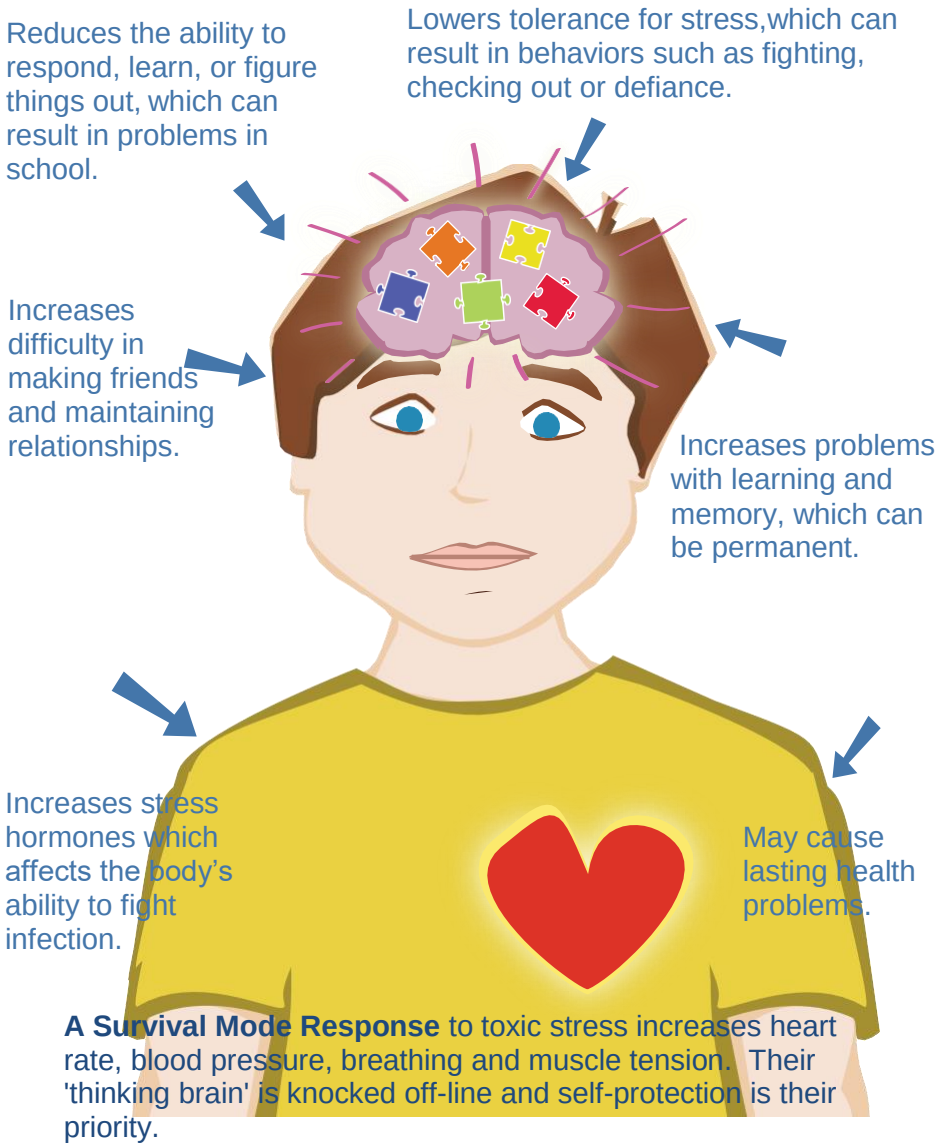
1. Emotional abuse
2. Physical abuse
3. Sexual abuse
4. Emotional neglect
5. Physical neglect
6. Mother treated violently
7. Household substance abuse
8. Household mental illness
9. Parental separation or divorce
10. Incarcerated household member
11. Bullying (by another child or adult)
12. Witnessing violence outside the home
13. Witness a brother or sister being abused
14. Racism, sexism, or any other form of discrimination
15. Being homeless
16. Natural disasters and war

**Exposure to childhood ACEs can increase the risk of:**

- Adolescent pregnancy
- Alcoholism and alcohol abuse
- Depression
- Illicit drug use
- Heart disease
- Liver disease
- Multiple sexual partners
- Intimate partner violence
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies

## How do ACEs affect health?

**Through stress.** Frequent or prolonged exposure to ACEs can create toxic stress which can damage the developing brain of a child and affect overall future health.

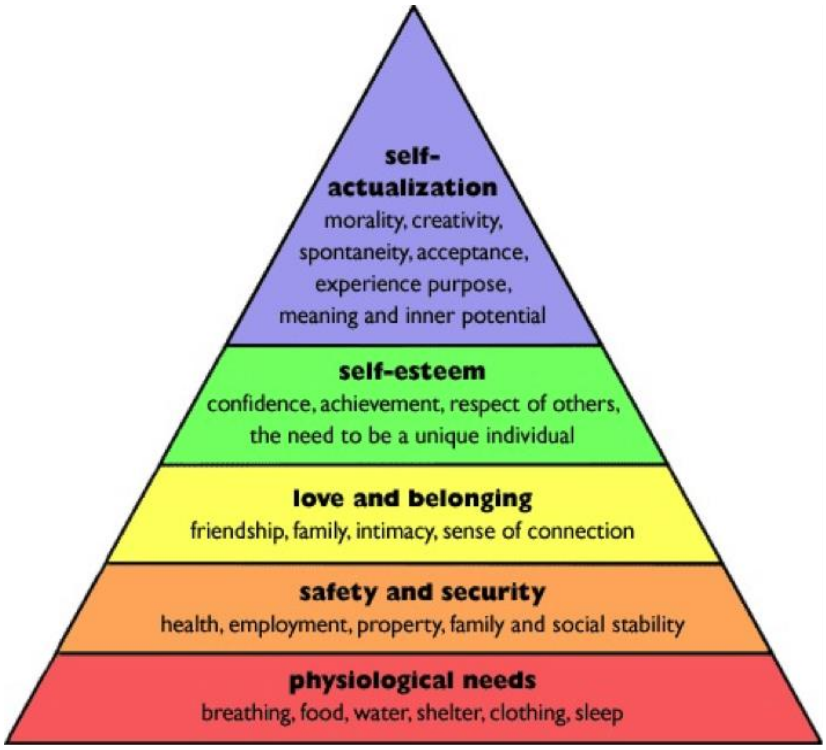



**A Survival Mode Response** to toxic stress increases heart rate, blood pressure, breathing and muscle tension. Their 'thinking brain' is knocked off-line and self-protection is their priority.

In other words: **"I can't hear you! I can't respond to you! I'm just trying to be safe!**

**(ACEs Connection Network)**

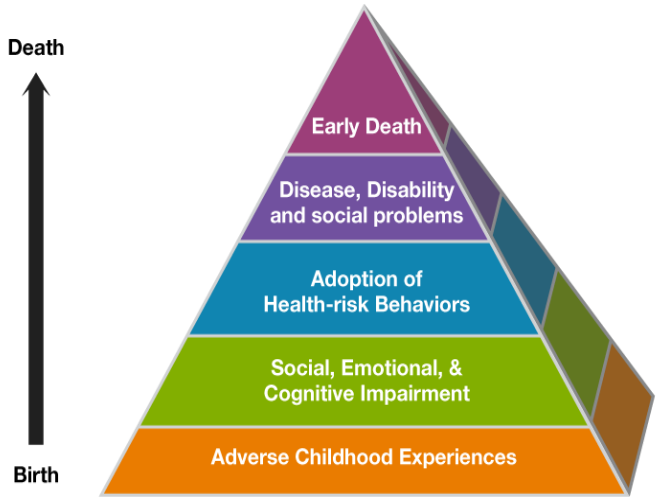
Maslow's Hierarchy of Needs (pictured below), theorizes that as humans, we can't reach a sense of self-worth, esteem, respect for others or self-actualization without first having our very basic needs met: physical needs, safety and love. Maslow's Hierarchy of Needs begins at the bottom assuming that our physiological needs (air, food, water, clothing, shelter), safety needs (absence due to war, domestic violence, abuse, PTSD, personal security, financial security, health & wellbeing), and need for love & belonging (family, friends, intimacy), must be met before we can fully develop healthy self-esteem (confidence, self worth, respect of others, self-respect), and self actualization (realizing one's full potential).




We know that children who are abused and neglected, experience interference with achievement of their most basic needs - those at the bottom of Maslow's pyramid and theoretically may have more difficulty achieving subsequent levels in the hierarchy.

Barbara Machina, writer, blogger and contributor to ACEsConnection, states it this way: *"If your base is unstable but you still make it to the top, you'll be much more likely to have the entire thing collapse on you . . . It just makes sense that you'll struggle to realize your full potential if you don't have food or security or other human connections, because those foundational needs will be your brain's major focus."*

Similarly, the ACEs pyramid shows how adversity in childhood can impact development and lead to poor outcomes in overall health and well-being. As the pyramid's shape suggests, ACEs don't guarantee bad outcomes, but can increase their likelihood.




In your work as a CASA Advocate, it is important to understand that ACEs can be intergenerational . . .

***Traumatized children*** become

↓

***Traumatized parents*** who have

↓

***Traumatized*** children

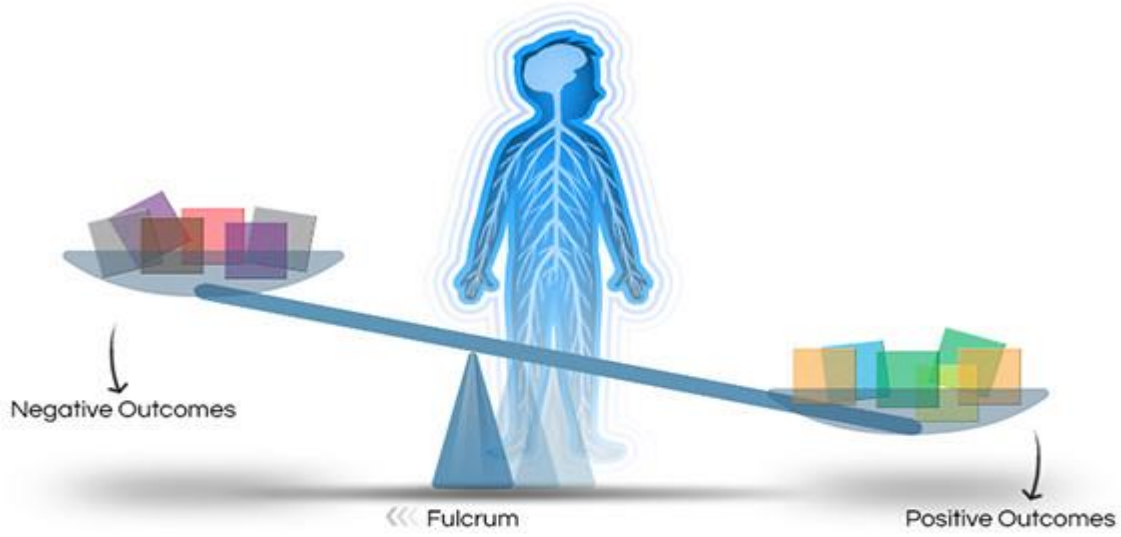
The good news is that the negative effects of ACEs can be minimized as ***resilience*** is increased. This is true across the age spectrum.

## Resilience

Resilience is the result of many protective factors. Protective factors enable us to counter the risk factors that endanger our health. Resilience is what helps us to bounce back when bad things happen and overcome the negative effects that ACEs can have. Research shows **resilience** helps reduce the effects of ACEs.

Science tells us that some children develop **resilience**, or the ability to overcome serious hardship, while others do not. Understanding why some children do well despite adverse early experiences is crucial, because it can inform more effective policies and programs that help more children reach their full potential.

One way to understand the development of resilience is to visualize a balance scale or seesaw. Protective experiences and coping skills on one side counterbalance significant adversity on the other.



Over time, the cumulative impact of positive life experiences and coping skills can shift the fulcrum's position, making it easier to achieve positive outcomes.

**The single most common factor for children who develop resilience is at least one stable and committed relationship with a supportive parent, caregiver, or other adult.** These relationships provide the personalized responsiveness, scaffolding, and protection that buffer children from developmental disruption. They also build key capacities—such as the ability to plan, monitor, and regulate behavior—that enable children to respond adaptively to adversity and thrive. This combination of supportive relationships, adaptive skill-building, and positive experiences is the foundation of resilience.

**Center on the Developing Child – Harvard University**

**Resources:**

Play Tipping the Scales: The Resilience Game to learn more.
**http://developingchild.harvard.edu/resources/resilience-game/**

## What does resilience look like?

### Building attachment and nurturing relationships

Listening and responding patiently in a supportive way, and paying attention to physical and emotional needs.

### Building social connections

Having family, friends and/or neighbors who support, help and listen.

### Meeting basic needs

Providing safe housing, nutritious food, appropriate clothing, and access to health care and good education.

### Learning about parenting and how children grow

Understanding how parents can help their children grow in a healthy way, and what to expect from children as they grow.

### Building social and emotional skills

Interacting in a healthy way with others, managing emotions and communicating feelings and needs.

**Resources:**

**ACES 101**
http://acestoohigh.com/aces-101/

**Triple-P Parenting**
www.triplep-parenting.net/ glo-en/home/

**Resilience Trumps ACEs**
www.resiliencetrumpsACEs.org

**CDC-Kaiser Adverse Childhood Experiences Study**
www.cdc.gov/violenceprevention/ace study/

**Zero to Three Guides for Parents**
http://www.zerotothree.org/about- us/areas-of-expertise/free-parent-brochures-and-guides/

Thanks to the people in the Community & Family Services Division at the Spokane (WA) Regional Health District for developing this handout for parents in Washington State, and sharing it with others around the world.

**Here are some resilience factors that may help mitigate the effects of Adverse Childhood Experiences:**

You believe your mother or father (or both) loved you as a child

Teachers, coaches, youth leaders, or ministers were there to help you as a child

Neighbors or parents' friends seemed to like you as a child

Hearing stories that when you were an infant, others enjoyed spending time with you, and that you also enjoyed it

Someone in your family cared how you were doing in school

You had relatives who made you feel better if you were sad or worried as a child

Family, neighbors, and friends talked often about making life better

Having people other than mother and father, who you believe loved you, take care of you sometimes as a child

You had rules in your house you were expected to abide by

When you felt bad, you could almost always find someone you trusted to talk to

People noticed you were capable and could get things done as a youth

You were an independent self-starter

You believed that life is what you make it

## Resilience: Risk and Protective Factors

There is rarely a single cause of child abuse or neglect. Risk factors for child abuse and neglect in families include *child-related factors*, *parent/caretaker-related factors*, *social-situational factors*, *family factors*, and *triggering situations*. These factors frequently coexist.

***Risk factors*** are "measureable characteristic[s] that heighten the probability of a worse outcome in the future" (Masten & Wright, 1998, p. 9). When combined with limited protective factors, they increase the probability of children experiencing child abuse or neglect.

***Protective factors*** are internal and external *resources* that help us to build our resilience. Protective factors include: parental resilience, nurturing attachments, social connections, having basic needs met (housing, food, clothing, and health care), knowledge of parenting and child development, and social/emotional competence.

While abuse, neglect and complex trauma certainly increase the likelihood of developing problems, some children don't experience problems, or do, to only a minor degree.

Remember the balance scale/seesaw example?

**Resilience** is evident when a child's **protective factors** tip toward positive outcomes — even when a heavy load of **risk factors** is stacked on the negative outcome side. Numerous studies of resilient people have identified the presence of protective factors—aspects of their personalities, their families, their significant relationships, or their experiences—that help them succeed.

## **Risk Factors** that may increase the likelihood of child abuse include:

## What you need to know as a CASA Advocate:

Additional **child-related risk factors**:

- Separation of a child from their parent during critical periods.
- Reduced positive interaction between parent/child during critical periods.
- Reduced positive interaction between parent and child.
- A child's inability to bond.
- Parental feelings of guilt, failure or inadequacy.

Additional **parent-caretaker related risk factors**:

- Parents may repeat their own childhood experience if no intervention occurred in their case and no new or adaptive skills were learned.
- Parent may have unrealistic expectations of a child, such as expecting a 4-year-old to wash his/her own clothes.
- Abusive and neglectful families may tend to avoid community contact and have few family ties to provide support. Distance from, or disintegration of, an extended family that traditionally played a significant role in child rearing may increase isolation.

Additional **social-situational related risk factors**:

- A child needs to be protected from separation from his/her family solely because of stressed economic conditions. Middle and upper income parents may experience job or financial stress as well— abuse is not limited to families in poverty.
- Values and norms concerning violence and force, including domestic violence; acceptability of corporal punishment and of family violence.
- Unacceptable child-rearing practices such as genital mutilation of female children, or a father sexually initiating female children.
- Cruelty in child-rearing practices (e.g., putting hot peppers in child's mouth, depriving child of water, confining child to room for days, or taping mouth with duct tape for "back talk").

Additional **family-related risk factors:**

- There is some indication that adult partners who are not the parents of the child are more likely to maltreat. Changes in family structure can also create stress in the family.
- Economic well-being is typically lower in single-parent families, and the single parent is at a disadvantage in trying to perform the functions of two parents.
- Adolescent parents are at high risk because their own developmental growth has been disrupted. They may be ill prepared to respond to the needs of the child because their own needs have not been met.
- Punishment-centered child-rearing styles have greater risk of promoting abuse.
- Scapegoating of a particular child will tend to give the family permission to see that child as the "bad" one.

With support, caregivers can build the safe, nurturing environments children need for healthy development. Through treatment and compassion, we can lessen the impact of ACEs on people's lives.

***We need to presume the clients we serve have a history of traumatic stress and exercise "universal precautions" by creating systems of care that are trauma-informed.***
*(Hodas, 2005)*

**Trauma informed care** is based on the fact that many, if not most, of the families we encounter in the child welfare system have suffered traumatic experiences and on an understanding that some traditional service delivery approaches may exacerbate trauma triggers. As Advocates, we are responsible for being sensitive to that fact, and for making recommendations for services and programs that are supportive and avoid re-traumatizing**.**

**An important piece of the trauma-informed approach is:**

Instead of asking "What's wrong with you?"

Ask/think: "What happened to you?"

**Activity: Identifying Protective Factors**

Read the chart on the next two pages detailing the risk factors and protective factors that can affect a person's resilience in response to adverse experiences. As you read, put a check mark next to the protective factors that you believe can be influenced. For example, a person has no control over his/her birth order, but he/she could become a better reader.

# Resilience Factors

| Risk Factors | Protective Factors |
|---|---|
| **Early Development**<br>⌋ Premature birth or complications<br>⌋ Fetal drug/alcohol effects<br>⌋ "Difficult" temperament<br>⌋ Long-term absence of caregiver in infancy<br>⌋ Poor infant attachment to mother<br>⌋ Shy temperament<br>⌋ Siblings within two years of child<br>⌋ Developmental delays<br><br>**Childhood Disorders**<br>⌋ Repeated aggression<br>⌋ Delinquency<br>⌋ Substance abuse<br>⌋ Chronic medical disorder<br>⌋ Behavioral or emotional problem<br>⌋ Neurological impairment<br>⌋ Low IQ (less than 80)<br><br>**Family Stress**<br>⌋ Family on public assistance or living in poverty<br>⌋ Separation/divorce/single parent<br>⌋ Large family, five or more children<br>⌋ Frequent family moves | **Early Development**<br>⌋ "Easy" temperament<br>⌋ Positive attachment to mother<br>⌋ Firstborn child<br>⌋ Independence as a toddler<br><br>**Family**<br>⌋ Child lives at home<br>⌋ Parent(s) consistently employed<br>⌋ Parent(s) with high school education or better<br>⌋ Other adult or older children help with childcare<br>⌋ Regular involvement in religious activities<br>⌋ Regular rules, routines, chores in home<br>⌋ Family discipline with discussion and fairness<br>⌋ Positive relationship with parent(s)<br>⌋ Perception of parental warmth<br>⌋ Parental knowledge of child's activities<br><br>**Child Competencies**<br>⌋ Reasoning and problem-solving skills<br>⌋ Good student<br>⌋ Good reader<br>⌋ Child perception of competencies<br>⌋ Extracurricular activities or hobbies<br>⌋ IQ higher than 100 |

| Risk Factors | Protective Factors |
|---|---|
| **Parental Disorders**<br>- Parent(s) with substance abuse problem<br>- Parent(s) with mental disorder(s)<br>- Parent(s) with criminality<br><br>**Parental Disorders**<br>- Witness to extreme conflict<br>- Removal of child from home<br>- Substantiated neglect<br>- Physical abuse<br>- Sexual abuse<br>- Negative relationship with parent(s)<br><br>**Social Drift**<br>- Academic failure or dropout<br>- Negative peer group<br>- Teen pregnancy, if female | **Child Social Skills**<br>- Gets along with other children<br>- Gets along with adults<br>- "Likeable" child<br>- Sense of humor<br>- Empathy<br><br>**Extra familial Social Support**<br>- Adult mentor outside family<br>- Support for child at school<br>- Support for child at church, mosque, synagogue, etc.<br>- Support for child from faith, spiritually<br>- Support for child from peers<br>- Adult support and supervision in community<br><br>**Outlooks and Attitudes**<br>- Internal focus of control as teen<br>- Positive and realistic expectation of future<br>- Plans for future<br>- Independent minded, if female teen |

**Resources:**

**Protective Factors Approaches in Child Welfare**
https://www.childwelfare.gov/pubPDFs/protective_factors.pdf

**FIVE PROTECTIVE FACTORS**
http://icfs.org/pdf/FiveProtectiveFactors.pdf


As an Advocate:

- Learn more about ACEs and share this information with others. Revisit the Resources section on pages 26 and 33 of this module.
- Recommend services that are trauma-informed, which can help a child build resilience and reduce ACEs impact on their well-being. (Call 211 for local resources.)
- Respond to others with better understanding by considering **what happened to instead of what is wrong** with someone.
- Help provide safe, stable and nurturing environments for the children you touch in your advocacy role.
- Advocate for strategies that help caregivers build resilience, parenting knowledge and access to resources.
- Please speak with your Coordinator about ACEs and Trauma-Informed Care in-service opportunities.

# Understanding Children

## Children's Needs

Children served by the CASA program come to the Court's attention because their parents or caretakers are not providing a ***minimum sufficient level of care*** (meeting their most basic needs) – food, clothing, shelter or security. When children enter the child welfare system, they have already experienced *at least* one adverse childhood experience, but more likely, several adverse experiences.

Usually, parents are their children's advocates; a CASA Advocate is needed only when the parents or caregivers cannot fulfill that advocacy role adequately. To make sure these children are protected from maltreatment and/or provided a ***minimum sufficient level of care***, the child protection system removes many of them from their homes and their primary relationships.

**Key parameters of the MSL standard:**

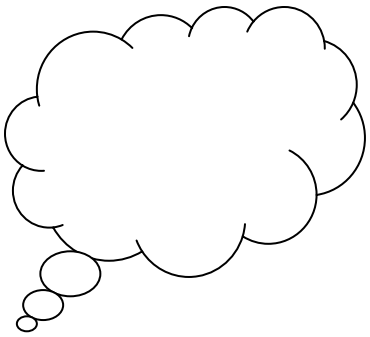
- The standard relates to a particular child.
- It is a set of minimum conditions, not an ideal situation.
- It is a relative standard, depending on the child's needs, social standards, and community standards. It will not be the same for every family or every child in a particular family.
- It remains the same when considering removal and when considering reunification.

While removal from the home may be necessary to ensure the children's safety, it does have consequences. As we learned earlier, in the process of keeping children safe, there is a risk of inflicting system induced trauma. It is important in your Advocacy, to be mindful of the effects of disturbing children's attachments to their primary caretakers, their home, neighborhood, school, friends, extended family members and pets.

As an Advocate:

- You must keep the child's needs clearly in mind. The child's needs are paramount.
- Healthy growth and development depend on adequately meeting basic needs (e.g., the ability to develop healthy, trusting relationships depends on basic needs being met).
- Children's needs depend on their age, stage of development, attachment to their family/caregivers, and reaction to what is happening around them.
- The essence of your role as a CASA Advocate is to identify the child's unmet needs and to advocate for those needs to be met, while ensuring permanency is achieved for the child at the earliest possible time.

In your advocacy role, consider the concept of Minimum Sufficient Level of Care and your understanding of Adverse Childhood Experiences. Ask yourself:



**Are the parent(s) able to provide for the following needs at a basic level?**

- **Physical (food, clothing, shelter, medical care, safety, protection)**
- **Emotional (attachment between parent and child)**
- **Developmental (education, special help for children with disabilities)**

**What risk factors are present in the family?**
**What protective factors are present in the family?**

**What other issues should be considered in determining if a parent can provide minimum sufficient level of care?**

## Separation, Grief and Loss

Understanding typical reactions of children and their parents to separation and loss provides motivation for fulfilling your advocate role. By integrating this understanding about separation and loss with information on child development, behavior, attachment, and a child's sense of time, you will be able to assess a child's needs more accurately.

All children in foster care have experienced tremendous loss. Even in the very best of foster care placements, children will experience loss of their familiar home surroundings, at least some disruption of daily routines, loss of personal belongings, pets, and family members—parents, siblings, and kin.


Even when the plan is reunification, and there is a good possibility that they will be returned home, children experience profound loss while they are separated from their caregivers. How a child experiences loss depends on many factors, including:

- The child's developmental level
- The significance of the people separated
- Whether the separation is temporary or permanent
- The degree of familiarity of the new surroundings

Of these factors, a child's developmental level will most deeply impact his or her understanding of the situation, and therefore influence how he or she responds to removal from their parents.

The following is a brief summary of how a child's developmental level will affect his or her response to grief and loss.

## Infancy

A child's major developmental task during infancy is establishing trust. When an infant experiences the profound loss of a parent or primary caregiver, the infant is at risk of losing his or her basic sense of trust in adults, and the world at large.

Specific grief and loss related behaviors include crying loudly, withdrawal, apathy, and mournful crying. Maintaining the infant's routine (as best as possible) can help reduce an infant's experience of loss. Infants also find comfort in familiar smells—although sometimes it goes against our instincts not to wash all of the infant's belongings, it gives the infant a sense of security to keep something that smells of the infant's home.

## Preschool: Two Years to Five Years of Age

At this age, children have not developed logical thinking abilities, and do not understand cause, effect, or permanence. Children of this age who experience loss may feel sadness, hopelessness, denial, and guilt. The fear of further loss may make the child clingy, anxious, and stubborn. The stress of loss can be reduced by answering the child's questions honestly, providing nurturing, stable interactions, and patiently attempting to connect with the child.

## School Age: Six Years to Eleven Years of Age

During this period, children are developing the ability to understand cause, effect, and time. They are beginning to form concrete and logical thoughts.

Grief can show itself in school or learning problems, and preoccupation with the loss of caregivers and or related worries. It is important for adults to be sympathetic listeners and to understand that the child's behavior and performance may be related to his or her overwhelming sadness.

## Adolescence: Twelve Years to Nineteen Years of Age

At this stage, children understand permanence and will grieve like an adult, following the five stages of grief described by Elizabeth Kubler-Ross (Shock/Denial, Anger/Protest, Bargaining, Depression, Resolution). Complicating the grief process is the adolescent's primary developmental task: forming his or her own identity. Issues of independence, resistance, and separation are already occurring—profound loss adds a tremendous amount of stress to his or her maturation process. When faced with loss, adolescents can turn to destructive behaviors such as substance abuse, eating disorders, depression, etc.

Adults can help adolescents deal with their conflicting emotions by helping them maintain their sense of identity, allowing them to make choices (that are not harmful), and by encouraging safe expressions and experiences of freedom and independence.

Foster children are often in a state of "limbo." When initially placed into care, it is often unknown whether the child will or will not return home. Until a birth parent's rights are relinquished or terminated, it is difficult for a child to complete the grief process. Ideally, caretakers who are providing care during this time of limbo will help children maintain some attachments with their parents. Through regular contact and visits, the child's family can reassure the child he or she is safe and loved.

When separation from the birth family is permanent, it is critical to help the child feel safe, secure, and prepared for the future. Honest, developmentally appropriate communication is essential. All parties involved in the child's life need to work closely together to develop a plan to help the child grieve and adapt during this transitional time between permanent homes.

*(Selena Berrier is an educational specialist with the Family & Children's Resource Program at the UNC-Chapel Hill School of Social Work)*

## Separation Anxiety

While all children would be expected to show signs of distress if removed from their homes, some children have extreme reactions. When a child experiences separation anxiety, the feelings of anxiety become so intense that they interfere with the child's ability to participate in daily activities.

### Characteristics of Separation Anxiety

- Recurrent excessive distress when separation from home or caretakers occurs or is anticipated and persistent/chronic worry that a person is being hurt.
- Persistent worry that an event will lead to separation from a caretaker (e.g., getting lost or being kidnapped).
- Reluctance or refusal to go to school, camp, or a friend's house because of the fear of separation.
- Clinging to a parent or shadowing the parent around the house.
- Excessive fear of being alone in the child's room, the child's house, or elsewhere.
- Reluctance or refusal to go to sleep without being near a caretaker or when away from home.
- Nightmares involving separation.
- Complaints of physical symptoms (headaches, stomachaches, nausea, vomiting) when separation from a caretaker takes place or is anticipated.
- Enuresis (bed wetting) and encopresis (soiling).

****Additional information on the impact of separating siblings is available to you as an Iowa CASA in-service training. Please speak with your Local Coordinator if you are interested in receiving that training.**

## Separation Experience of Parents

You may observe that both a parent and a child have a similar reaction to the separation experience. Grief and loss are experienced universally as a series of emotions including denial, anger, bargaining, sadness, and, eventually, acceptance. These are the stages of grief.

Sometimes these reactions proceed in order; sometimes people skip around or cycle back to a previous stage, as they work through their personal reactions to grief and loss.

Also, remember that many parents of children in foster care have histories of adult and/or childhood trauma. What this means is a parent's past or present trauma can make it difficult for them to work effectively with case workers, service providers, the Court and CASAs towards reunification with their children.

How does separation and loss impact children (and their parents) when they are removed from their home?

How might this knowledge impact recommendations you make on a child's case?

## Psychological Issues for Children

The issues explored in this module can impact any child, not just those who have come to the attention of the child welfare system. It is not the purpose of this training to make you an expert in child development or child psychology, but to help you recognize warning signs that might indicate the need for an assessment. If you learn about or observe troubling behaviors of the child(ren) on your assigned case, a referral for an assessment may be in order.

During a case, you may wish to recommend that a child undergo psychological assessment.

| Possible Reasons to Refer for Psychological Assessment | |
|---|---|
| **Dysfunctional and negative behavior** | tantrums, a demanding personality, excessive crying and whining, delinquency, defiance of rules and limits |
| **Developmental concerns** | perceptual and motor problems, speech and learning problems, delayed development, school readiness determination |
| **Educational problems** | inadequate performance and progress, aggressive behavior, dislike of or disinterest in school |
| **Sleeping and eating problems** | infant feeding and nursing problems, excessive crying, bulimia, anorexia nervosa, over- and under-eating, suspected nutritional deficiencies that may be contributing to learning problems, sleep and behavior problems, or fatigue |
| **Toilet training problems** | encopresis (soiling), enuresis (bed wetting), or excessive fear of going into the bathroom |
| **Behavioral issues** | poor self-control, lack of motivation, irresponsibility, lying, stealing, dependence/independence, conflict, setting fires, “mean” behavior toward animals and others, self-inflicted injuries, and sexuality issues |

| | |
|---|---|
| **Family problems** | sibling conflict, dysfunctional communication, attachment and separation problems, aggressiveness, and abuse; problems prompted by divorce, custody issues, separation, adoption, termination of parental rights, moving, visitation issues, grieving and death issues; parents' negative feelings for the child, poor relationship indicators, conflict over discipline, and family arguing |
| **Medical considerations** | psychological or physiological reactions to stress, adjustment to illness of the child or family member, terminal illness of the child or family member, physical or sexual abuse, neglect, drug and alcohol abuse by child or other family member |
| **Psychiatric concerns** | personality disorder, cyclothymic mood disturbance (alternate periods of elation and depression), disassociation and psychic numbing (emotional shutting down and flat affect), excessive fears, harming others, and psychotic behavior such as hallucinations and thought disorder |

***It is critical that you do not try to diagnose.***

## Educational Issues for Children

Chaos in a child's life often results in the neglect of educational concerns. Parents or caregivers may not be available to help with homework, attend school conferences, or make referrals for evaluation when concerns arise. Children entering foster care often have school issues. Addressing these issues can allow a more positive experience for a child who hasn't known the rewards of success in school.

Five out of every 30 students in a typical Iowa classroom live with a parent who has experienced four or more ACEs. Children living with parents who have high ACE scores may be in situations of toxic stress; the child's behavior in school—acting out, withdrawing, failing academically—may indicate that they are under stress, too. *ACEs Too High news, October, 2015*

Teachers, who see the child every day, have a wealth of knowledge about the child's behavior, attitude, likes and dislikes, and about the best ways to communicate with that child. In addition, many Iowa schools are beginning to deliver trauma-informed education.

As you inquire about a child's progress in school, you may discover that your child has special educational needs and should be referred for an evaluation. In some areas, an abundance of resources may be available for special-needs children, and in other areas, you may have to advocate for the creation of needed resources.

Children from racial, ethnic, or cultural backgrounds, different from the majority culture, may also have special needs based on discriminatory practices in the educational system. For instance, children may face racist or homophobic taunts; teachers who believe they can't learn; and/or testing that is racially/culturally biased. It is important to realistically assess the difficulties of a child in school and determine what role the educational system, as well as the child's particular school setting, may be playing in creating or sustaining those problems.

As an Advocate, you will:

- Maintain regular contact with teachers.
- Determine whether the child has all the services he/she needs to be as successful as possible in school.
- If not, advocate for the child to receive those services.
- Refer for an academic evaluation, if appropriate.

# Understanding Families

## The Cultural Sensitivity Lens


An essential tool to use when looking at families is the cultural sensitivity lens. Strengths don't look the same in every family. Family structures, rules, roles, customs, boundaries, communication styles, problem-solving approaches, parenting techniques, and values may be based on cultural norms and/or accepted community standards.

A family is defined by its members, and each family defines itself. A family can include people of various ages who are united through biology, marriage, or adoption or who are so closely connected through friendships or shared experience that they are taken to be family members.

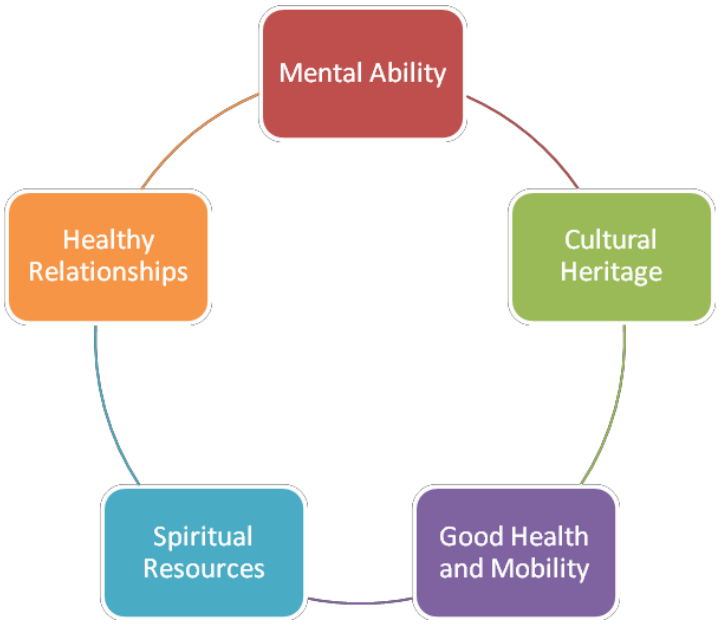
Families are dynamic and constantly evolving, redefining roles and relationships, welcoming in new members, and taking on new ideas and world views as diverse cultures intersect. Each family has a unique culture of its own in addition to the external cultures with which it and individual members affiliate. Osher, T., Garay, L, Jennings, B., Jimerson, D., Markus, S., & Martinez, K. (2011), Closing the Gap: Cultural Perspectives on Family- Driven Care. The Technical Assistance Partnership for Child and Family Mental Health, accessed at http://www.tapartnership.org/docs/ ClosingTheGap_FamilyDrivenCare.pdf

*In the context of the Advocate role, cultural competence means cultivating an open mind and new skills and meeting people where they are, rather than expecting them conform to your standards.*

It's important to understand that child-rearing practices vary within and across cultures, as well. For instance, the following mainstream US child-rearing practices may be viewed as harmful to children by people from other countries: isolating children in beds or rooms of their own at night, making children wait for food when they are hungry, requiring children to wear painful braces on their teeth, forcing young children to sit in a classroom all day or allowing infants to "cry it out."

Conversely, practices that are culturally acceptable elsewhere may be misunderstood in the United States. One example is the Southeast Asian practice of “coin rubbing,” a traditional curing method in which heated metal coins are pressed on a child’s body. This practice is believed to reduce fevers, chills and headaches. Because it generally leaves red streaks or bruises, it can easily be misdiagnosed as child abuse by those who don’t understand the intention behind this cultural practice.

Some of the different skills and resources people in different cultures and socioeconomic classes may use to deal with stress and problems can be found below.




• **Mental ability** allows a person to access and use information.

• **Cultural heritage** provides context, values and morals for living in the world.

• **Good health and physical mobility** allow for self-sufficiency.

• **Spiritual resources** give purpose and meaning to people’s lives.

• **Healthy relationships** nurture and support.

In addition:

- **Emotional resources** provide support and strength in difficult times.
- **Informal support systems** provide a safety net (e.g., money in tight times, care for a sick child, job advice).
- **Role models** provide appropriate examples of and practical advice on achieving success.

As an Advocate, you will:

- Continuously be challenged to identify individual and family strengths.
- Commit yourself to understanding yourself and families through a lens of cultural sensitivity and cultural humility.
- Be asked to recognize that while behaviors, attitudes, and practices may be different than what you identify as the “norm”, they may be identified as a strength when considered through a lens of cultural sensitivity and humility.

As an Advocate, you will need to remember:

- Culture is dynamic and ever-changing and does not solely determine behavior. The practice of cultural competence and humility is a *lifelong process* that will and should evolve over time.

## Identifying Family Strengths

At the start of this module, the importance of identifying a family's strengths was mentioned. Your ability to identify strengths in families depends partially on which lens -- the resource (or strengths-based) lens or the deficit lens -- you use in your work with families. The lens you choose will also influence your work with others involved in the case. Using a strength-based approach means acknowledging the resources that exist in a family (including extended family) and tapping into them. For instance, you may identify a relative who can provide a temporary or permanent home for a child; you may help a parent reconnect with a past support system; or you may identify healthy adults who in the past were important to a child or family. Using a resource lens creates more options for resolving issues, and empowers and supports children and families.

REMINDER: *Your own self awareness is critical in practicing Cultural Humility and in assessing the strengths and needs of a child and family*.

**Activity: Part 1 – Resources vs. Deficits**

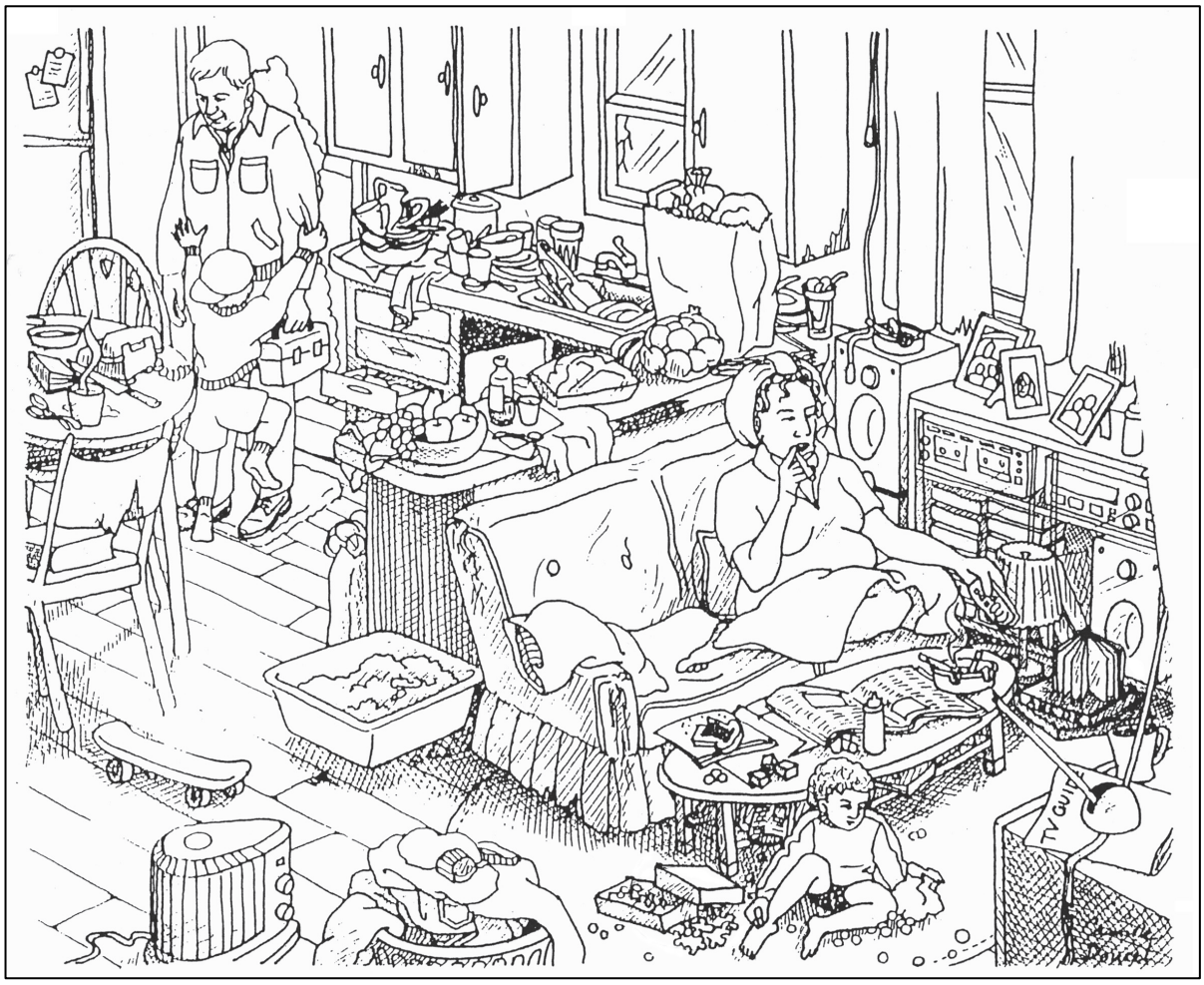
Please review the Resource vs. Deficits box below. Consider which perspective you take when assessing a situation. Do you generally look at life, circumstances, and people through a Resource Lens or a Deficit Lens?

| **If I look through a RESOURCE or STRENGTH-BASED lens, I am likely to:** | **If I look through a DEFICIT lens, I am likely to:** |
|---|---|
| Look for positive aspects | Look for negative aspects |
| Empower families | Take control or rescue |
| Create options | Give ultimatums or advice |
| Listen | Tell |
| Focus on strengths | Focus on problems |
| Put the responsibility on the family | See the family as incapable |
| Acknowledge progress | Wait for the finished product |
| See the family as expert | See service providers as experts |
| See the family invested in change | Impose change or limits |
| Help identify resources | Expect inaction or failure |
| Avoid labeling | Label |
| Inspire with hope | Deflate the family's hope |

Adapted from materials developed by CASA for Children, Inc., Portland, Oregon

## Activity: Part 2 – Identify the Strengths

Considering what you've just read about viewing families through a resource or deficit lens, look at the illustration of a family home. Note 12 to 15 **positive aspects/strengths** of the household pictured.




Used with permission from the artist, Camille Doucet for Iowa Court Appointed Special Advocate Pre-Service Training.

Family strengths observed in the photo:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

## STRESS IN FAMILIES

Just as all families have strengths and resources, at some point all families encounter change, stress and perhaps even crisis. For example, the family moves, a parent is laid off, childcare arrangements fall through, a new stepfamily comes into being, the car breaks down, a child becomes ill, the rent goes up and on it goes. The families you will encounter in your work as an Advocate are, by definition, under stress and are likely to be in crisis – if for no other reason than that the state is now involved in determining whether their child remains in their care and custody. Some families cope well and adapt effectively to stress and crisis; others do not and become overwhelmed. Families that are not able to cope well are often isolated from resources, face a variety of challenges, and are stressed by numerous problems that compound one another. These families may develop patterns that lead to, and then perpetuate, abuse and neglect.

In your work with children and families, you will encounter poverty, mental health issues, substance misuse or abuse, domestic violence and child abuse/neglect.

**Activity: Stress Assessment**

Complete the Stress Level Assessment, on the next page, as it pertains to you. Next, consider Amanda Meyers and complete the Stress Level Assessment from her perspective.

## Stress Level Assessment

*For each event that has occurred within the past 12 months, record your corresponding score in the first box. You will complete Amanda's score, as well. If an event occurred more than once, multiply the score for that event by the number of times the event occurred, and record that score. Total all the scores and compare to the range of scores to determine whether your susceptibility to illness and mental health problems in the near future is low, mild, moderate or high.*

| LIFE EVENT | You | Amanda | VALUE |
|---|---|---|---|
| 1. Death of spouse or partner | | | 100 |
| 2. Divorce | | | 73 |
| 3. Marital or relationship separation | | | 65 |
| 4. Jail term | | | 63 |
| 5. Death of close family member | | | 63 |
| 6. Personal injury or illness | | | 53 |
| 7. Marriage | | | 50 |
| 8. Fired at work | | | 47 |
| 9. Marital or relationship reconciliation | | | 45 |
| 10. Retirement | | | 45 |
| 11. Change in health of family member | | | 44 |
| 12. Pregnancy | | | 40 |
| 13. Sex difficulties | | | 39 |
| 14. Gain new family member | | | 39 |
| 15. Business adjustment | | | 39 |
| 16. Change in financial status | | | 38 |
| 17. Death of a close friend | | | 37 |
| 18. Change to different line of work | | | 36 |
| 19. Change in number of arguments with spouse or partner | | | 35 |
| 20. Mortgage or loan for major purchase (home, etc.) | | | 31 |
| 21. Foreclosure of mortgage or loan | | | 30 |
| 22. Change in responsibilities at work | | | 29 |
| 23. Son or daughter leaving home | | | 29 |
| 24. Trouble with in-laws | | | 29 |

| LIFE EVENT | You | Amanda | VALUE |
|---|---|---|---|
| 25. Outstanding personal achievement | | | 28 |
| 26. Spouse or partner begins or stops work | | | 26 |
| 27. Begin or end school | | | 26 |
| 28. Change in living conditions | | | 25 |
| 29. Revision of personal habits | | | 24 |
| 30. Trouble with boss | | | 23 |
| 31. Change in working hours or conditions | | | 20 |
| 32. Change in residence | | | 20 |
| 33. Change in schools | | | 20 |
| 34. Change in recreation | | | 19 |
| 35. Change in religious activities | | | 19 |
| 36. Change in social activities | | | 18 |
| 37. Mortgage or loan for lesser purchase (car, TV, etc.) | | | 17 |
| 38. Change in sleeping habits | | | 16 |
| 39. Change in number of family get-togethers | | | 15 |
| 40. Change in eating habits | | | 15 |
| 41. Vacation | | | 13 |
| 42. Major holiday celebration | | | 12 |
| 43. Minor violation(s) of the law | | | 11 |

***Your Susceptibility to illness and Mental Health Problems:***

LOW = less than 149

MILD = 150 to 200

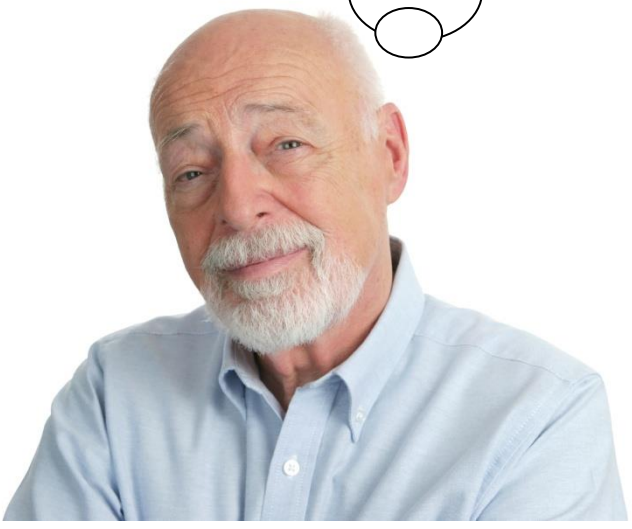
MODERATE = 200 to 299

HIGH = more than 300

## Stress & Entering the Child Welfare System

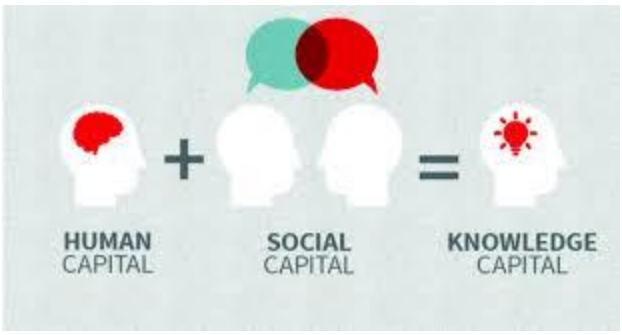
All of the issues identified in the Stress Level Assessment relate to real-life events. Consider the following:

- How many additional points would you assign to having your child removed from your home by the child welfare system?
- How might stress affect a family's interactions with Advocates and other child welfare professionals?
- How does your new understanding of how stress, trauma and ACEs increase the chance of illness and/or mental health issues impact potential recommendations for children?



## POVERTY in Families

Families and their children experience poverty when they are unable to achieve a minimum, decent standard of living that allows them to participate fully in mainstream society. One component of poverty is material hardship. Although we are all taught that the essentials are food, clothing, and shelter, the reality is that the definition of basic material necessities varies by time and place. In the United States, we all agree that having access to running water, electricity, indoor plumbing, and telephone service are essential to 21st century living even though that would not have been true 50 or 100 years ago.




To achieve a minimum but decent standard of living, families need more than material resources; they also need "human and social capital." Earlier, we identified some family "resources", such as mental ability, cultural heritage, physical health, spiritual faith and healthy relationships. Human and social capital include education, basic life skills, and employment experience, as well as less tangible resources such as social networks and access to civic institutions. These non-material resources provide families with the means to get by, and ultimately, to get ahead. Human and social capital help families improve their earnings potential and accumulate assets, gain access to safe neighborhoods and high-quality services (such as medical care, schooling), and expand their networks and social connections.

.Please visit this link and view the video, Toxic Stress of Poverty OR Type this link in to your browser: https://www.youtube.com/watch?v=KdTiPGVZNes

The experiences of children and families who face economic hardship are far from uniform. Some families experience hard times for brief spells (situational poverty) while others experience chronic poverty (generational poverty – two or more generations). For some, the greatest challenge is

inadequate financial resources, whether insufficient income to meet daily expenses or the necessary assets (savings, a home) to get ahead. For others, economic hardship is compounded by social isolation. These differences in the severity and depth of poverty matter, especially when it comes to the effects on children.

Americans often talk about “poor people” as if they are a distinct group with uniform characteristics and somehow unlike the rest of “us.” In fact, there is great diversity among children and families who experience economic hardship. Research shows that many stereotypes just aren’t accurate.

Although most portrayals of poverty in the media and elsewhere reflect the experience of only a few, a significant portion of families in America have experienced economic hardship, even if it is not life-long. Americans need new ways of thinking about poverty that allow us to understand the full range of economic hardship and insecurity in our country. In addition to the millions of families who struggle to make ends meet, millions of others are merely one crisis — a job loss, health emergency, or divorce — away from financial devastation, particularly in this fragile economy. Recently, more and more families have become vulnerable to economic hardship.
National Center for Children in Poverty

## Poverty Myths & Stereotypes

### The Hard Numbers

More than 40% of Americans between the ages of 25 and 60 will be poor for at least a year of their lives. Over the same period, more than half of Americans will be poor or nearly poor, with income at 150% of the poverty line. Today, more than 47 million Americans live in poverty, including 1 in 5 children.

In 2013, the federal government placed the poverty line at a maximum of $23,550 in gross cash income for a family of four; $19,530 for a family of three; $15,510 for a family of two, and $11,490 for an individual.

People living in poverty have to make tough choices with their money all day, every day, with no room for error but plenty of judgment from others. Many people who do not live in poverty have a tendency to criticize the poor and blame them for their supposed laziness, lack of intelligence, or willingness to make bad decisions. They believe in a just world, where the poor must have done something to deserve their fate.

This belief helps fuel the many myths and stereotypes that negatively impact those living in poverty in the U.S. Here are just a few of them:

***MYTH:* Poor people are unmotivated and have weak work ethics.**

**The Reality:** Poor people do not have weaker work ethics or lower levels of motivation than wealthier people. Although poor people are often stereotyped as lazy, two-thirds of people living in poverty work an average of 1.7 jobs; 83% of children from low-income families have at least one employed parent; and close to 60% of children have at least one parent who works full-time and year-round. According to the Economic Policy Institute, poor working adults spend more hours working each week than their wealthier counterparts.

***MYTH:* A huge chunk of my tax dollars supports welfare recipients.**

**The Reality:** Welfare costs about 1% of the Federal Budget. The majority of those living in poverty do not receive government welfare assistance.

***MYTH:* Those who get on welfare stay on welfare.**

**The Reality:** Of the poor that receive welfare assistance, more than half stop receiving benefits after a year, 70% within two years, and 85% within four years.

***MYTH:* Social mobility is possible by working hard.**

**The Reality:** This is not our grandfathers' era where people could simply "pull themselves up by their bootstraps," assuming that was ever really true. Our current economy requires workers to be more skilled than in the past. Meanwhile, jobs for unskilled workers simply don't pay enough. The minimum wage 50 years ago was worth $15.29 in 2014 dollars. Today, an education provides the bootstraps people need for social mobility. However, many people who live in poverty cannot afford the costs associated with secondary education.

***MYTH:* Poor parents are uninvolved in their children's learning, largely because they do not value education.**

**The Reality:** Low-income parents hold the same attitudes about education that wealthy parents do. Low-income parents might be less likely to attend school functions or volunteer in their children's classrooms—not because they care less about education, but because they have less access to school involvement than their wealthier peers. They are more likely to work multiple jobs, to work evenings, to have jobs without paid leave, and to be unable to afford child care and public transportation.

***MYTH:* Poor people have babies to get more welfare.**

**The Reality:** Welfare recipients in Iowa receive $64 per month for additional children – well below the costs of raising a child – and in some states the amount is zero. The average welfare family is no larger than the average non-recipient American family. Welfare benefits are not a significant incentive for childbearing.

***MYTH:* Poverty has little lasting impact on children.**

**The Reality:** Research is clear that poverty is the single greatest threat to children's well-being. Poverty can impede children's ability to learn and contribute to social, emotional, and behavioral problems. Poverty

also can contribute to poor physical and mental health, and poor self-esteem. Risks are greatest for children who experience poverty when they are young and/or experience deep and persistent poverty.

***MYTH: Poverty is a minority issue.***

**The Reality:** Poverty is not solely a minority issue. Poverty affects people of all races. Of the Americans living in poverty today, 42% are White, 29% are Hispanic or Latino, 25% are Black or African American, and 4% are Asian. However, poverty has a disparate impact on people of color.

***MYTH: Poor people tend to abuse drugs and alcohol.***

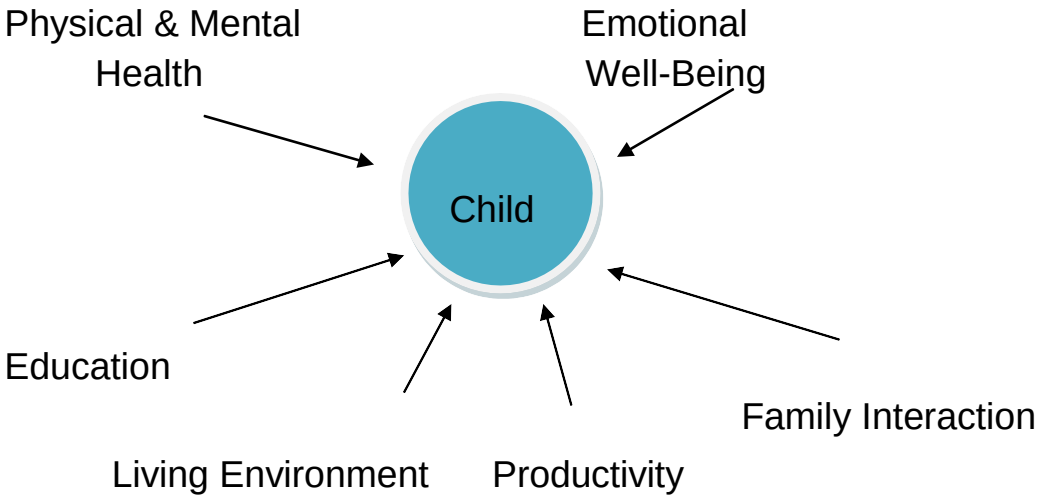
**The Reality:** Poor people are no more likely than their wealthier counterparts to abuse alcohol or drugs. Although drug sales are more visible in poor neighborhoods, drug use is equally distributed across poor, middle class, and wealthy communities. Studies have found that alcohol consumption is significantly higher among upper middle class, white high school students than among poor black high school students. This finding supports a history of research showing that alcohol abuse is far more prevalent among wealthy people than among poor people.

JUST HARVEST JUST THE FACTS: Poverty Myths & Stereotypes January, 2015

## Effects of Poverty on Children

According to the Children's Defense Fund, at the end of 2013, nearly 15 million children in America lived below the official poverty level — $23,834 for a family of four, based only on cash income. This is 2 million children more than were living in poverty at the end of 2004. Over 40% of these children lived in extreme poverty, at less than half the poverty level. The youngest children were most likely to be poor, with more than 1 in 5 children under age 5 living in poverty during the years of rapid brain development.

Research shows that while poverty is an indicator of academic achievement, *it does not necessarily have an impact on emotional well-being.*




Research has also demonstrated that living in poverty has a wide range of effects on the physical and mental health and well-being of our nation's children. Poverty impacts children within their various contexts at home, in school, and in their neighborhoods and communities.

- Poverty is linked with negative conditions, such as substandard housing, homelessness, inadequate nutrition and food insecurity, inadequate child care, lack of access to health care, unsafe neighborhoods, and under-resourced schools, which adversely impact our nation's children.

- Poorer children and teens are also at greater risk for several negative outcomes such as poor academic achievement, school dropout, abuse and neglect, behavioral and socio-emotional problems, physical health problems, and developmental delays.
- These effects are compounded by the barriers children and their families encounter when trying to access physical and mental health care.
- Economists estimate that child poverty costs an estimated $500 billion a year to the U.S. economy; reduces productivity and economic output by 1.3 percent of GDP; raises crime and increases health expenditure (Holzer et al., 2008).

As an Advocate, what you need to know:

Poverty and academic achievement

- Poverty has a particularly adverse effect on the academic outcomes of children, especially during early childhood.
- Chronic stress associated with living in poverty has been shown to adversely affect children's concentration and memory which may impact their ability to learn.
- The National Center for Education Statistics reports that in 2008, the dropout rate of students living in low-income families was about four and one-half times greater than the rate of children from higher-income families (8.7 percent versus 2.0 percent).
- The academic achievement gap for poorer youth is more pronounced for low-income Black and Hispanic children compared with their more affluent White peers.
- Under resourced schools in poorer communities struggle to meet the learning needs of their students and aid them in fulfilling their potential.
- Inadequate education contributes to the cycle of poverty by making it more difficult for low-income children to lift themselves and future generations out of poverty.

Poverty and psychosocial outcomes

- Children living in poverty are at greater risk of behavioral and emotional problems.
- Some behavioral problems may include impulsiveness, difficulty getting along with peers, aggression, attention-deficit/hyperactivity disorder (ADHD) and conduct disorder.
- Some emotional problems may include feelings of anxiety, depression, and low self-esteem.
- Poverty and economic hardship is particularly difficult for parents who may experience chronic stress, depression, marital distress and exhibit harsher parenting behaviors. These are all linked to poor social and emotional outcomes for children.
- Unsafe neighborhoods may expose low-income children to violence which can cause a number of psychosocial difficulties.

Poverty and physical health

- Children and teens living in poorer communities are at increased risk for a wide range of physical health problems:
    - Low birth weight.
- Poor nutrition which is manifested in the following ways:
    - Inadequate food which can lead to food insecurity/hunger.
    - Lack of access to healthy foods and areas for play or sports which can lead to childhood overweight or obesity.
- Chronic conditions such as asthma, anemia, and pneumonia.
- Risky behaviors such as smoking or engaging in early sexual activity.
- Exposure to environmental contaminants, e.g., lead paint and toxic waste dumps.
- Exposure to violence in their communities which can lead to trauma, injury, disability, and mortality

## IMPACT OF SUBSTANCE ABUSE/ADDICTION ON FAMILIES

### Fast Facts

- An estimated 12% of children in this country live with a parent who is dependent on or abuses alcohol or other drugs (HHS, Substance Abuse and Mental Health Services Administration [SAMHSA], Office of Applied Studies, 2009).
- Once a report is substantiated, children of parents with substance use issues are more likely to be placed in out- of-home care and more likely to stay in care longer than other children (Barth, Gibbons, & Guo, 2006; HHS, 1999).
- The National Survey of Child and Adolescent Well-Being (NSCAW) estimates that 61% of infants and 41% of older children in out-of-home care are from families with active alcohol or drug abuse (Wulczyn, Ernst, & Fisher, 2011).

### Definitions

Psychoactive substances, whether legal (for instance, alcohol) or illegal, impact and alter moods, emotions, thought processes, consciousness and behavior. These substances are classified as stimulants, depressants, opiates and morphine derivatives, cannabinoids, dissociative anesthetics, or hallucinogens based on the effects they have on the people who take them.

Substance abuse is evident when a person displays behavior harmful to self or others as a result of using the substance. This can happen with only one instance of use, but it generally builds over time, eventually leading to addiction. Addiction, also called chemical dependency, involves the following:

- Loss of control over the use of the substance.
- Continued use despite adverse consequences.
- Development of increasing tolerance to the substance.
- Withdrawal symptoms when the drug use is reduced or stopped.

## Causes

According to the American Society of Addiction Medicine, substance-related disorders are biopsychosocial, meaning they are caused by a combination of biological, psychological, and social factors.

## Treatment

The field of addiction treatment recognizes an individual's entire life situation. Treatment should be tailored to the needs of the individual and guided by an individualized treatment plan based on a comprehensive assessment of the affected person, as well as his/her family. Treatment can include a range of services depending on the severity of the addiction, from a basic referral to 12-step programs, to outpatient counseling, intensive outpatient/day-treatment programs, and inpatient/residential programs.

Recovery is a process and relapse is part of the disease of addiction. The process of recovery includes holding substance abusers accountable for what they do while using. While it is important to act in an empathetic manner toward people with addictions, they must be held accountable for their actions. For additional information on particular drugs, see the National Clearinghouse for Alcohol and Drug Information website at *http://ncadi.samhsa.gov* .

## Impact on Children

Children whose parents abuse drugs and alcohol are almost three times likelier to be abused and more than four times likelier to be neglected than children of parents who are not substance abusers. Substance abuse and addiction are the primary causes of the dramatic rise in child abuse and neglect cases since the mid-1980s. National Center on Addiction and Substance Abuse at Columbia University, *No Safe Haven*, 1999.

A dilemma that often arises is the conflict between the legal mandate and the child's need for permanence (Adoption and Safe Families Act) and the long-term treatment (including inpatient treatment) that substance-abusing parents may need. If a parent is in treatment, consideration should be given to placing the child with the parent rather than in foster care. Although it is often the only available option, the child may feel punished when he/she is placed in foster care or away from the parent. The focus should be to support success in treatment, not to punish the parent by withholding the child.

### Effects of Substance Abuse on Parenting

It is important to remember that when a parent is involved with drugs or alcohol to a degree that interferes with his/her ability to parent effectively, a child may suffer in a number of ways:

- A parent may be emotionally and physically unavailable to the child.
- A parent's mental functioning, judgment, inhibitions, and/or protective capacity may be seriously impaired, placing the child at increased risk of all forms of abuse and neglect, including sexual abuse.
- A substance-abusing parent may "disappear" for hours or days, leaving the child alone or with someone unable to meet the child's basic needs.
- A parent may spend the family's income on alcohol and/or other drugs, depriving the child of adequate food, clothing, housing, and healthcare.
- The resulting lack of resources often leads to unstable housing, which results in frequent school changes, loss of friends and belongings, and an inability to maintain important support systems (churches, sports teams, neighbors).
- A child's health and safety may be seriously jeopardized by criminal activity associated with the use, manufacture, and distribution of illicit drugs in the home.
- A parent's substance abuse may lead to criminal behavior and periods of incarceration, depriving the child of parental care.
- Exposure to parental abuse of alcohol and other drugs, along with a lack of stability and appropriate role models, may contribute to the child's own substance abuse.
- Prenatal exposure to alcohol or other drugs may impact a child's development.

**What the Child Experiences**

A child may experience a parent's substance abuse in the following ways:

- **Broken Promises**

  Parents may break promises to go somewhere or do something with the child/family, not drink that day, or not get high. The children may believe they are not loved or important enough for their parents to keep promises.

- **Inconsistency & Unpredictability**

  Rules/limits may change constantly, and parents may be loving one moment and abusive the next.

- **Shame & Humiliation**

  Alcohol or drugs may take over and turn an otherwise great parent into an embarrassment.

- **Tension & Fear**

  Because the children of substance-abusing parents never know what will happen next, they often feel unsafe at home.

- **Paralyzing Guilt & an Unwarranted Sense of Responsibility**

  A child may think they cause their parents' behavior. Part of the disease is to blame others for it, and the child grows up thinking that if they were a better student, more obedient, more reliable, etc., their parents would not use alcohol/drugs.

- **Anger & Hurt**

  Children may feel neglected, mistreated, and less important in their parents' lives than the alcohol or drugs.

- **Loneliness & Isolation**

  Because the family denies/hides the problem and often will not even discuss it among themselves, the children, with no one to talk to about the issue, think they are the only ones with this problem.

- **Lying as a Way of Life**

  Children may feel they have to cover for the failure of the parent, or account for his/her deviant behavior.

- **Feeling Responsible/Obligates**

  Children may feel it is their job to run the home, care for younger siblings and hide the problem from authorities in order to protect the parent.

## Gambling Addiction

Gambling addiction, while not as common as mental health issues, substance abuse and domestic violence, is just as damaging to a family's stability and resources as the other issues.

The negative effects of problem or compulsive gambling on a family are widespread in this country. According to the National Council on Problem Gambling, an estimated 2 million U.S. adults (1 percent of the population) are compulsive or pathological gamblers. Another estimated 4 to 6 million (2 to 3 percent) can be considered problem gamblers. An estimated one-third (35 percent) of adult problem gamblers have children at home under the age of 18.

| How Gambling Addiction Impacts a Family | |
|---|---|
| Financial | Out-of-control gambling and repeated gambling losses take a tremendous toll on the family finances. |
| Breakdown In Family Relationships | Dealing with the stress and tension resulting from a gambler's behavior jeopardizes family bonds. When a spouse, children, siblings and other family members can't trust the gambler, feel no sense of security, have no confidence in the gambler or even fear for their future, the result is a breakdown in the family relationships. |
| Emotional Devastation | Anxiety, guilt, shame, depression, insomnia, behavioral problems and emotional insecurity begin to afflict all the family members that are closest to or living in the same environment as the problem or compulsive gambler. |
| Violence | The bigger the losses, the longer the out-of-control gambling goes on, the greater the potential for serious bodily harm to family members. |
| Isolation | Shame, avoidance of friends, secrecy and hiding the pain further magnify the isolation the family feels as the gambler's behavior gets more and more out of control. |

## The Trauma-Addiction Connection

While experiencing a trauma doesn't guarantee that a person will develop an addiction, research clearly suggests that trauma is a major underlying source of addiction behavior. These statistics (culled from a report issued by the National Center for Post-Traumatic Stress Disorder and the Department of Veterans Affairs) show the strong correlation between trauma and alcohol addiction:

- Sources estimate that 25 and 75 percent of people who survive abuse and/or violent trauma develop issues related to alcohol abuse.
- Accidents, illness or natural disasters translate to between 10 to 33 percent of survivors reporting alcohol abuse.
- A diagnosis of PTSD (post-traumatic stress disorder) increases the risk of developing alcohol abuse.
- Female trauma survivors who do not struggle with PTSD face increased risk for an alcohol use disorder.
- Male and female sexual abuse survivors experience a higher rate of alcohol and drug use disorders compared to those who have not survived such abuse.

In addition, ACE findings suggest that a **major** factor, if not the **main** factor, underlying addiction is **ACEs that are concealed from awareness by shame, secrecy, and social taboo**.

(National Child Traumatic Stess Network, 2008), Beverly Tobiason, Psy.D., Chris Swenson-Smith, MSW, Krissa Ericson, MSW

As an Advocate:

- Understand the connection between trauma, ACEs and addiction.
- Be educated about the power of addiction and resources (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Alateen, and Nar-Anon).
- Support those family members who are willing to deal with the substance abuse problem, even if the person with the substance dependence is not.
- Address your own personal feelings about individuals you have known that have struggled with substance abuse.
- Discuss with your Coordinator/CASA Coach your personal history so that they can assist you in remaining objective.

- Has substance abuse or other addictions impacted your life?
- Based on any personal experience and what you now know of families' strengths and resources, how might that impact recommendations you will make on behalf of children you are assigned to advocate for?
- Consider that what are conventionally viewed as Public Health ***problems*** are often personal ***solutions*** to long concealed adverse childhood experiences.

## IMPACT OF MENTAL ILLNESS ON FAMILIES

**Fast Facts**

- An estimated one in five adults in the United States suffers from a diagnosable mental disorder in any given year.
- The vast majority of people with mental illness are not dangerous.
- Mental illness is treatable with various combinations of therapy and drugs.

### Definition

Definitions of mental illness have changed over time, across cultures, and across national, and even state boundaries.

Mental illness is diagnosed based on the nature and severity of an individual's symptoms. If a person meets the diagnostic criteria as set forth in the *Diagnostic and Statistical Manual of Mental Disorders (DSM),* currently in its fifth edition, he/she may be diagnosed with a particular disorder such as depression, anxiety, post-traumatic stress disorder, schizophrenia, alcohol dependence, and so on. The term "dual diagnosis" indicates that an individual has both a mental health disorder and a substance abuse problem.

### Causes

No single model or perspective accounts for all instances of mental illness. Some disorders have a predominately biological or neurological basis; others seem to be related to life experiences, trauma, or difficulties in communication.

## Impact on Children and Families

The biggest obstacle, facing those suffering from mental illness, is the lack of appropriate, effective treatment. This lack may result from misunderstanding the need for treatment or being afraid to seek it due to the stigma associated with mental illness in US culture. It may also result from a lack of access to treatment. There may not be treatment available in a person's community, or the person may not be able to pay for it.

Untreated mental illness can lead to isolation and despair for individuals and families. Some parents may be so incapacitated by anxiety or depression that they are unable to care for their children. Or some may have hallucinations or delusions, which make them a danger to themselves, or their children. It is critical for you as an Advocate to focus less on a parent's diagnosis and more on his/her ability to provide a safe home for the child. The degree to which a parent's functioning is impaired will vary from mild to severe. It is important to note that with medication and/or therapy most people with mental illness can function normally.

Mental illness can affect a parent's level of functioning. In addition, many adults have limited intellectual abilities or specific learning disabilities. These limitations range in severity.

## Treatment

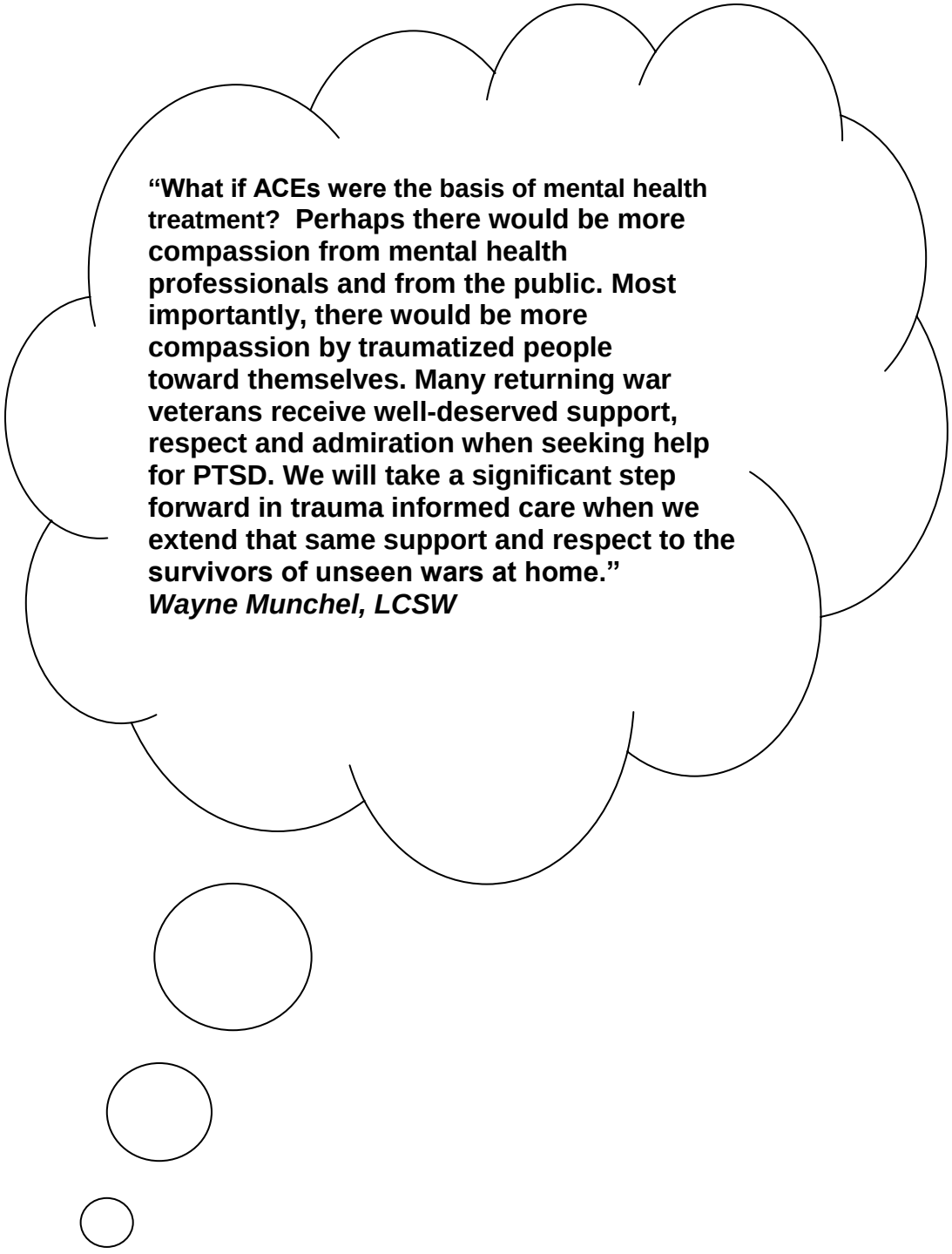
Availability of mental health treatment varies, and its effectiveness depends on a variety of factors. A well-designed treatment plan takes individual differences into account. Healers and practices from a person's cultural tradition (e.g., the use of prayer or meditation) can be included with other, more "Western" approaches, which might include specialized inpatient treatment (e.g., for substance abuse), medication, individual and/or group counseling, self-help groups (e.g., Alcoholics Anonymous, Overeaters Anonymous, and other 12-step programs), and education or training (e.g., parenting classes or anger management training).

It is especially important in the area of mental health and mental illness to consider whether a parent's mental health concern is related to trauma and/or ACEs.

## Indicators of possible need for professional assessment:

| | |
|---|---|
| **Social Withdrawal** | Characterized by "sitting and doing nothing"; friendlessness (including abnormal self-centeredness or preoccupation with self); dropping out of activities; decline in academic, vocational, or athletic performance |
| **Depression** | Includes loss of interest in once pleasurable activities; expressions of hopelessness or apathy; excessive fatigue and sleepiness, or inability to sleep; changes in appetite and motivation; pessimism; thinking or talking about suicide; a growing inability to cope with problems and daily activities |
| **Thought Disorders** | Evidenced by confused thinking; strange or grandiose ideas; an inability to concentrate or cope with minor problems; irrational statements; peculiar use of words; excessive fears or suspicions |
| **Expression of Feelings Disproportionate to Circumstances** | May include indifference even in important situations; inability to cry or excessive crying; inability to express joy; inappropriate laughter; anger and hostility out of proportion to the precipitating event |
| **Behavior Changes** | Such as hyperactivity, inactivity, or alternating between the two; deterioration in personal hygiene; noticeable and rapid weight loss; changes in personality; drug or alcohol abuse; forgetfulness and loss of valuable possessions; bizarre behavior (such as skipping, staring, or strange posturing); increased absenteeism from work/school. As part of the assessment, it is important to determine if domestic violence and/or substance abuse are contributing or causal factors. This is a task for professionals. |

For additional material on Mental Health Information, see http://www.nimh.nih.gov/; http://www.samhsa.gov/index.aspx; or http://www.nlm.nih.gov/medlineplus/medlineplus.html .


"What if ACEs were the basis of mental health treatment? Perhaps there would be more compassion from mental health professionals and from the public. Most importantly, there would be more compassion by traumatized people toward themselves. Many returning war veterans receive well-deserved support, respect and admiration when seeking help for PTSD. We will take a significant step forward in trauma informed care when we extend that same support and respect to the survivors of unseen wars at home."
*Wayne Munchel, LCSW*

# THE IMPACT OF DOMESTIC VIOLENCE ON FAMILIES

## Fast Facts

- Estimates of violence against a current or former spouse, boyfriend, or girlfriend range from nearly 1 million to 4 million incidents each year.

US Department of Justice, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends,* 1998.

- Domestic violence is statistically consistent across racial and ethnic boundaries.

Bureau of Justice Statistics Special Report, *Violence Against Women: Estimates from the Redesigned Survey*, 1995.

- In 2001, women accounted for 85% of the victims of intimate partner violence and men accounted for approximately 15% of the victims.

Bureau of Justice Statistics Crime Data Brief, *Intimate Partner Violence,* February 2003.

- As many as 95% of domestic violence perpetrators are male.

A Report of the Violence Against Women Research Strategic Planning Workshop sponsored by the National Institute of Justice in cooperation with the US Department of Health and Human Services, 1995.

## Definition

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks and economic coercion that adults or adolescents use to control their current or former intimate partners (e.g., spouses, girlfriends/boyfriends, lovers, etc.).

Domestic violence ranges from threats of violence, to hitting, to severe beating, rape, and even murder. Victims and perpetrators are from all age, racial, socioeconomic, sexual orientation, educational, occupational, geographic, and religious groups. Abuse by men against women is by far the most common form, but domestic violence does occur in same-sex relationships, and some women do abuse men.

When a battered partner leaves the family home (or the batterer is forced to leave), the batterer feels a loss of control formerly exerted. This makes the batterer even more likely to be violent. This increased level of danger makes many victims reluctant to leave, even when the consequence of staying may be the placement of children in foster care.

## Causes

Domestic violence stems from one person's need to dominate and control another. Domestic violence is not caused by illness, genetics, gender, alcohol or other drugs, anger, stress, the victim's behavior, or relationship problems. However, such factors may play a role in the complex web of factors that result in domestic violence. Domestic violence is learned behavior; it is a choice.

- It is learned through observation, experience, and reinforcement (perpetrators perceive that it works).
- It is learned in the family, in society, and in the media.

## Legal System Response

The legal system can respond to domestic violence as a violation of criminal and/or civil law. If the violence has risen to the level of physical assault, it can be prosecuted criminally. Law enforcement can press charges in criminal court with the victim as a witness. Victims may also secure a restraining/protective order.

One setting in which the legal system and domestic violence may intersect is a court hearing regarding allegations of child abuse and/or neglect. As an Advocate, you should be aware that a determination of domestic violence within the child's home will significantly influence placement decisions and what is expected of the non-abusing parent to retain/regain custody. The standard risk assessment conducted by child welfare agencies to evaluate whether a child needs to be removed from his/her home generally includes domestic violence as a factor that negatively relates to the child's safety at home. A child found to be living in a violent home is more likely to be removed. A child abuse or neglect case also may be substantiated against the battered parent for "failure to protect" the child because the victim did not leave the batterer, even if the victim lacked the resources to do so or it was not safe to do so.

## Barriers to Leaving a Violent Relationship

For people who have not experienced domestic violence, it is hard to understand why the victim stays or returns again and again to re-enter the cycle of violence. The primary reason given by victims for staying with their abusers is fear of continued violence and the lack of real options to be safe with their children. *This fear of violence is real; domestic violence usually escalates when victims leave their relationships.* In addition to fear, the lack of shelter, protection, and support create barriers to leaving. Other barriers include lack of employment and legal assistance; immobilization by psychological or physical trauma; cultural/religious/family values; hope or belief in the perpetrator's promises to change; and the message from others (possibly police, friends, family, counselors, etc.) that the violence is the victim's fault and that she could stop the abuse by simply complying with her abuser's demands. Leaving a violent relationship is often a process that takes place over time, as the victim can access resources she needs. The victim may leave temporarily many times before making a final separation.

Adapted from *Domestic Violence: A National Curriculum for Children's Protective Services,* Anne Ganley and Susan Schechter, Family Violence Prevention Fund, 1996.

## Impact on Children

> *"Children who live in battering relationships experience the most insidious form of child abuse. Whether or not they are physically abused by either parent is less important than the psychological scars they bear from watching their fathers beat their mothers. They learn to become part of a dishonest conspiracy of silence. They learn to lie to prevent inappropriate behavior, and they learn to suspend fulfillment of their needs rather than risk another confrontation. They expend a lot of energy avoiding problems. They live in a world of make- believe."* Lenore Walker, author of *The Battered Woman*

Children in families where there is domestic violence are at great risk of becoming victims of abuse themselves. Studies indicate this group is 15 times more likely to experience child abuse than children in nonviolent homes are. Over half the children in families where the mother is battered are also abused. In some cases, children may try to intervene and protect

their mothers, getting caught in the middle of the violence. In most cases, however, children are also targets of the violence.

At least 75% of children whose mothers are battered witness the violence. In some cases, the batterer deliberately arranges for the child to witness it. The effect on children's development can be just as severe for those who witness abuse as for those who are abused. Witnessing violence at home is even more harmful than witnessing a fight or shooting in a violent neighborhood. It has the most negative impact when the victim or perpetrator is the child's parent or caregiver.

Statistics from "Children: The Forgotten Victims of Domestic Violence," Janet Chiancone, *ABA Child Law Practice Journal,* July 1997.

**Activity: 911**

**WARNING – the content of this audio recording contains content that could be distressing.**

Listen to the 911 call made by a little girl named Lisa, at this link: https://www.youtube.com/watch?v=Th1FI7DxQ3Q

If you have difficulty accessing this link, search **911 call Lisa** on another browser (Chrome, Foxfire, etc.) for a format that your computer supports.

**If you or someone you know needs help, please call the National Domestic Violence Hotline at 1-800-799-7233 or 911 for immediate assistance.**

*Additional training on Domestic Violence and its impact on families and children is available as an in-service training. Please speak with your Coordinator for more information.*

As an Advocate:

- Be both knowledgeable and concerned about domestic violence.

- Children from violent homes are at a higher risk for abuse than other children. According to A Nation's Shame, a report compiled by the US Advisory Board on Child Abuse and Neglect, "Domestic violence is the single, major precursor to child abuse and neglect fatalities in the US."

- Determine the best interest of the child.

- Be alert to any signs that domestic violence has recurred or that contact between the batterer and the victim is ongoing if that might compromise the child's safety.

- Consider the effects of ongoing violence/trauma in the home on the caregivers and the child.

**<u>The foremost issue is the safety of the child.</u>**

## IMPORTANCE OF FAMILY TO A CHILD

As discussed in previous training sections, a minimum sufficient level of care (MSL) means that all basic needs are met and the child is not harmed physically, sexually, or emotionally. The optimum level of care means that the child has considerably more than the minimum: things like regular access to a library, tutoring, a community of faith, sports, Scouts, music lessons, college, a loving extended family.

The state intervenes when basic needs are not met, not when a family is unable or unwilling to provide an optimal level of care.

The idea that a minimum sufficient level of care should be the standard for families is often difficult for Advocates to embrace. It feels counterintuitive, as though it defies common sense. You may be tempted to ask, "Wouldn't any child be better off in a family without the limitations that are present in this situation?" *The truth is that most would not*.

Despite all of the issues a family might face – poverty, substance abuse, mental illness, domestic violence – a minimum sufficient level of care is the standard. Children suffer an overwhelming sense of loss when removed from their homes: the loss of love; of security; of the familiar; of their heritage; of control in their lives. They experience feelings of worthlessness and the pain of separation is terrible for most children. Despite the bad things that have happened in their lives, most children involved in the child welfare system love their families and want desperately to be reunited with them.

Take a moment to think back to your own childhood. Whatever it was like, how would you have felt if a stranger came one day to take you away to live with a “better” family?

If parenting hovers at the minimum sufficient level of care, the child protective services system and the court likely will not get involved. If the child’s basic needs are not being met and/or the child is being abused, the child protective services system steps in. Once the system has intervened, the responsibilities of the parent (e.g., to seek substance abuse treatment or learn parenting skills) and those of the child protective services agency (e.g., to provide visitation, arrange counseling, etc.) are spelled out in agreements (Case Permanency Plan) that are enforced by court orders.


Ideally, the Case Permanency Plan (CPP) will help the parent move at least to a minimum sufficient level of care. The steps for the parents in the CPP need to be small and measurable. If the steps are too big or complex, the parent may give up, causing the family situation to deteriorate and the child to lose the chance to ever return home. If the steps are not measurable, success cannot be determined. For example, a parent can “attend parenting classes” for six months without ever making a change in behavior. If the CPP specifies that the parents are “able to describe and apply five ways to discipline their child without spanking,” both the parents and any observer will be able to tell whether the task gets accomplished.

As a CASA Advocate, it is important to know:

- The CASA Program has the inherent belief that children belong with their family if at all possible.
- Many of the children you serve as an Advocate will go home.
- It is your role to advocate for the services necessary so the child can go home safely.
- If the child cannot be returned home safely, what is in the child's best interest? This is not an easy question to answer.
- As an Advocate, you start with the assumption that a child's family is usually the best setting for raising and nurturing that child. This is true even if the family's lifestyle, beliefs, resources, and actions are radically different from yours.
- As long as the child's family meets or can be helped to meet the minimum sufficient level of care required for the safety of that child, the child belongs with his/her family.

In considering what the **minimum sufficient level of care** is for any one child, it is important to remember the key parameters of this standard:

- It relates to a particular child.
- It is a set of minimum conditions, not an ideal situation.
- It is a relative standard, depending on the child's needs, social standards, and community standards. It will not be the same for every family or every child in a particular family.
- It remains the same when considering reunification as when considering removal.

As an Advocate, with regard to the Case Permanency Plan, you should routinely ask the question of both parents and case manager, "How will you know when each requirement is met?"

## Concurrent Planning

In Modules 1 and 2 you learned about concurrent planning. It involves identifying and working toward a child's primary permanent goal as Plan A (reunification with the birth family), while simultaneously identifying and working on a secondary goal as Plan B (such as guardianship with a relative or adoption by a relative or non-relative). It is designed to ensure that permanency still awaits a child if reunification with parents is not possible.

Benefits of Concurrent Planning:

- ❖ Fewer moves for children;
- ❖ Placement with a permanent family more quickly;
- ❖ Fewer problems of attachment and trust;
- ❖ Strategies and services matched to the needs of families offer the best opportunity for changing the behavioral patterns that led to the child's removal.

**As a CASA Advocate, it is important to know the factors found to decrease time to permanency:**

- **Caseworker consistency**
  *One* worker change reduced the odds of a child attaining permanency within the year by 52%.
- **Fewer Placements**
  Each additional placement reduced the odds of attaining permanency within a year by 32%.
- **Adequate family financial resources**
  Extremely poor families were 90% less likely to achieve permanency in 12 months.
- **More days of parental visitation per week**
  Each day of visitation tripled the odds of permanent placement within 12 months.
- **Clear identification of the Concurrent Plan** in the written case plan and family involvement in case planning.
- **Expectation of PERMANENCY**
  URGENCY is required to assure timely permanence.

Compiled by the Child and Family Services Division, Iowa Department of Human Services
Iowa Department of Human Services Practice Bulletin, July 2008 – Permanency for Children: Concurrent Planning

## Components of Effective Concurrent Planning

- Individualized and early assessment of the conditions that led to out-of-home placement, the strengths of the family, and the likelihood of reunification within 12–15 months
- Early paternity determination
- Early aggressive search for birth family resources for achieving permanency
- Early identification and consideration of all permanency options
- Frequent and constructive use of parent-child visitation as part of the reunification efforts
- Full disclosure to the parents of problems, changes, possible consequences, timelines, and alternative permanency decision making
- Initial placement with a relative or foster/adopt family who can, if necessary, become the permanent home of the child
- Effective and timely court hearings with firm timelines for permanency decision making; during which time, documented steps are taken to achieve reunification and an alternative permanency option;
- Involvement of foster/adoptive and kinship caregivers in teaching and skill- building with birth parents
- Ways the family, the court, and DHS will know when the family change process has been adequately completed
- Case planning that includes early and targeted strategies for family change to improve parental capacity and move to safe case closure and permanency for the child
- Ongoing evaluation of progress, tracking and adjusting, to find what works for the family; lack of progress suggests that planned strategies are either wrong or underpowered OR;
- When reunification is not possible within a reasonable period of time, another permanency option can be considered.

## Pulling it all together – Next Steps

- The next step in the pre-service curriculum is the two-day, in-person training of Modules 4 and 5, where you will practice the CASA role and learn more about children, diversity in families and communicating as an Advocate.
- Please write down any questions you may have on the concepts you learned in this module, and bring them with you to the two-day, in-person training.
- Bring this Module with you to the pre-service two-day, in- person training, on Module 4 and 5. You will apply the concepts covered during this personal study and use these activities during upcoming discussions.
- **Before** attending the two-day, in-person training, please read the following documents (pp.72-112) in the Myers Case Study:

- Family Team Decision Making Meeting (FTDM) Notes dated 10/29/2006
- Family Interaction Plan dated 11/12/2006
- Shiloh's Teacher's E-Mail to CASA dated 04/10/2007
- CASA Report to Court (Review Hearing) dated 04/13/2007
- DHS Case Permanency Plan: Parts A & C – Aubrey dated 04/13/2007
- DHS Case Permanency Plan: Parts A & C – Shiloh dated 04/13/2007
- DHS Case Permanency Plan: Parts A & B & C – Jackson dated 04/13/2007
- Review Order dated 04/20/2007

You will need the information in these documents to continue your advocacy for the Myers children.


Please complete the evaluation on the next page and **send it to the Module 4 Trainer to finalize your Module 4-5 registration.**

**Page intentionally left blank for evaluation to be removed and submitted.**

# Evaluation Module 3

Please complete this Module 3 evaluation *in its entirety* and submit to your Coordinator *prior* to attending Module 4-5 training for review. *An incomplete evaluation will prohibit attendance at the in-person Module 4-5 training.*

Did you learn what was intended? (6 is high and 1 is low)

| Learning Outcomes | Ratings | | | | | |
|---|---|---|---|---|---|---|
| | 6 | 5 | 4 | 3 | 2 | 1 |
| 1. I can explain why awareness of diversity and cultural competence among Advocates is important and how it benefits the children and families they work with | | | | | | |
| 2. . I understand the impact of psychological trauma and toxic stress on children and their parents | | | | | | |
| 3. I can explain the relationship between resilience, protective factors and risk factors | | | | | | |
| 4. I know four risk factors associated with child abuse and neglect and how it affects the way a CASA Advocate does their work | | | | | | |
| 5. I can explain how Concurrent Planning enhances a child's opportunity for permanence | | | | | | |
| 6. The content of this session was | | | | | | |
| 7. The notebook materials were | | | | | | |
| 8. The activities were | | | | | | |
| 9. Overall, I rate this session | | | | | | |

**Continue your evaluation by answering the following questions:**

**What does the acronym "ACE"s stand for?**

**How can ACEs impact a child's development?**

**How can ACEs interfere with a parent's ability to parent their child?**

**What is Resilience and why is it important?**

**What are Risk Factors?**

**What are Protective Factors?**

**What is one reality about poverty that you didn't know before?**

**What was your reaction to the 911 call activity?**

**How old was Lisa?**

**How many children were in the Toxic Stress of Poverty video?**

**Name** _____ **Date** _____

**Thank you for your participation and feedback!**

**Please return this evaluation to the Module 4 Trainer *prior* to your scheduled in-person Module 4 and 5 training.**